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Supreme Court, U.S.
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No. 87-

IN THE

Supreme Court of the United States

OCTOBER TERM, 1987

GENERAL MOTORS CORPORATION and
AMERICAN NATIONAL RED CROSS,
Petitioners,

v.

WILLIAM M. BENNETT, CONWAY H. COLLIS,
ERNEST J. DRONENBERG, JR., RICHARD NEVINS,
GRAY DAVIS, and BRUCE BUNNER,
Respondents.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

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QUESTION PRESENTED

ERISA preempts "all State laws" that "relate to" employee benefit plans except, *inter alia*, those which also "regulate insurance." 29 U.S.C. § 1144. The State of California taxes insurance companies that provide excess-risk insurance to ERISA employee welfare benefit plans. The tax is calculated based on the amounts paid by plans for insurance *and* the amounts paid by plans to employees in benefits. The question in this case is whether section 514 of ERISA, 29 U.S.C. § 1144, preempts the tax insofar as it is assessed on the amounts paid by plans to employees in benefits.*

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* Petitioners' statement pursuant to Rule 28.1 of the Rules of this Court is set forth in the Appendix at 1a.

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Respondents.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

General Motors Corporation ("GMC") and the American National Red Cross ("Red Cross") respectfully petition this Court to issue a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit to review that court's holding that the states can tax ERISA-covered welfare benefits if the legal incidence of the tax falls on the plan's insurance company.[1] The Court of Appeals justified elevating the

[1] Respondents are state officials responsible for administering the challenged tax. The Court of Appeals vacated the District

formal incidence of the tax over its substance by asserting that this Court's decision in *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985), required that result. Thus, only this Court can resolve whether it in fact intended the *Metropolitan* decision to sanction indirect—but purposeful—state taxation of ERISA benefits notwithstanding ERISA's command that "any State tax law relating to employee benefit plans" be preempted. 29 U.S.C. § 1144(b)(5)(B)(i).

OPINIONS BELOW

The United States District Court for the Central District of California entered judgment in favor of petitioners GMC and the Red Cross in an initial opinion reported at 600 F. Supp. 76, and a modified opinion reported at 626 F. Supp. 439. Appendix at 16a, 25a. The United States Court of Appeals for the Ninth Circuit reversed the District Court in an opinion reported at 815 F.2d 1305. Appendix at 3a. The Ninth Circuit denied appellees' Petition for Rehearing with Suggestion for Rehearing En Banc in an unreported opinion on August 14, 1987. Appendix at 35a.

JURISDICTION

The Court of Appeals rendered its decision reversing the District Court's judgment in favor of petitioners on April 24, 1987, and denied petitioners' timely Petition for Rehearing on August 14, 1987. On October 31, 1987, Justice O'Connor granted petitioners' application to extend to December 14, 1987 the time in which to file a Petition for Writ of

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Court's injunction against the principal agency in the taxing process, the California State Board of Equalization, on Eleventh Amendment grounds. Appendix at 10a.

Certiorari. Petitioners invoke the jurisdiction of this Court pursuant to 28 U.S.C. § 1254(1).

STATUTES INVOLVED

1. Section 514(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1144(a) (emphasis added), provides in part:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter *relate to* any employee benefit plan . . . .

2. Section 514(b)(2)(A) of ERISA (the "saving clause"), 29 U.S.C. § 1144(b)(2)(A) (emphasis added), provides:

> Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which *regulates insurance*, banking, or securities.

3. Section 514(b)(2)(B) of ERISA (the "deemer clause"), 29 U.S.C. § 1144(b)(2)(B), provides in part:

> [No] employee benefit plan . . . shall be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts . . . .

4. Section 514(b)(5)(B)(i) of ERISA, 29 U.S.C. § 1144(b)(5)(B)(i) (emphasis added), provides:

> (B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) of this section—
>
> (i) *any State tax law* relating to employee benefit plans

5. Section 514(c)(2) of ERISA, 29 U.S.C. § 1144(c)(2) (emphasis added), provides:

> The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly *or indirectly*, the terms and conditions of employee benefit plans covered by this subchapter.

STATEMENT OF THE CASE

A. Statutory Background

In 1974, Congress enacted the Employee Retirement Income Security Act ("ERISA"). Its "crowning achievement" was the "reservation to Federal authority the sole power to regulate the field of employee benefit plans." 120 Cong. Rec. 29197 (1974) (remarks of Rep. Dent). To accomplish that end, Congress enacted a reticular set of provisions designed to shield plans from direct or indirect state action without unduly restricting the states' traditional authority in the fields of insurance, banking, and securities regulation. 29 U.S.C. § 1144.

In *Pilot Life Insurance Co. v. Dedeaux*, 107 S. Ct. 1549 (1987), this Court summarized the "complexity" of ERISA's preemption provisions and recognized

Congress' intent, underscored repeatedly in the legislative history, to insulate employee benefit plans from any form of state intrusion:

> To summarize the pure mechanics of the provisions quoted above: If a state law "relate[s] to . . . employee benefit plan[s]," it is pre-empted. § 514(a). The saving clause excepts from the pre-emption clause laws that "regulat[e] insurance." § 514(b)(2)(A). The deemer clause makes clear that a state law that "purport[s] to regulate insurance" cannot deem an employee benefit plan to be an insurance company. § 514(b)(2)(B).
>
> . . . We have observed in the past that the express pre-emption provisions of ERISA are deliberately expansive, and designed to "establish [employee benefit] plan regulation as exclusively a federal concern." *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523, 101 S.Ct. 1895, 1906, 68 L.Ed.2d 402 (1981). As we explained in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98, 103 S.Ct. 2890, 2900, 77 L.Ed.2d 490 (1983):
>
> > "The bill that became ERISA originally contained a limited pre-emption clause, applicable only to state laws relating to the specific subjects covered by ERISA. The Conference Committee rejected those provisions in favor of the present language, and indicated that section's pre-emptive scope was as broad as its language. See H.R.Conf.Rep. No. 93-

> 1280, p. 383 (1974); S.Conf.Rep. No. 93-1090, p. 383 (1974)."
>
> The House and Senate sponsors emphasized both the breadth and importance of the pre-emption provisions. . . .
>
> "It should be stressed that with the narrow exceptions specified in the bill, the substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans. This principle is intended to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of law." [120 Cong. Rec.] 29933.
>
> . . . .
>
> Given the "statutory complexity" of ERISA's three pre-emption provisions, *Metropolitan Life, supra,* at 740, 105 S.Ct., at 2389, as well as the wide variety of state statutory and decisional law arguably affected by the federal pre-emption provisions, it is not surprising that we are again called on to interpret these provisions.

Id. at 1552-53.

B. The State Law at Issue

The State of California has the power to tax "gross premiums received" by insurance companies that do

business in the state. In *Metropolitan Life Insurance Co. v. State Board of Equalization*, 32 Cal. 3d 649, 186 Cal. Rptr. 578, 652 P.2d 426 (1982),[2] the California Supreme Court held that the phrase "gross premiums received" included not only the amount actually paid by an employee benefit plan to an insurance company to secure an excess-risk level of insurance coverage, but also the amount of benefits paid directly from the general assets of the sponsoring employer to employees and their dependents under the terms of the plan. *See* Appendix at 37a.

Under an excess-risk policy, the plan sponsors "are responsible for paying all claims up to a trigger point, an aggregate level of claims specified annually," and the insurance company "is responsible for paying all claims above that point." Appendix at 6a. The employee benefit plan remains largely "self-insured" or "uninsured" as a matter of federal law notwithstanding its purchase of an excess-risk policy. *See General Electric Co. v. Gilbert*, 429 U.S. 125, 128 n.3 (1976) (plan sponsor "remains, for all practical purposes, a self-insurer" notwithstanding purchase of "insurance policy from the Metropolitan Life Insurance Co."). As a consequence of the excess-risk arrangement, the insurance company does not receive from the plan, as it would under a "full insurance" arrangement, amounts used to pay expected (*i.e.*, pre-trigger point) benefits, but rather receives payment only for insuring against the risk of unexpected claim experience and for ancillary expenses.

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[2] The *Metropolitan Life* case, though decided in 1982, involved tax years preceding the 1974 passage of ERISA. The California Supreme Court thus did not address the preemption issue.

To reach its conclusion that benefit amounts not actually received by the insurer were nevertheless taxable as "gross premiums," the California Supreme Court first held that all employers that sponsor employee benefit plans are "mere agents" of insurance companies "as a matter of law." Appendix at 51a. The court then determined that the employer agents receive "premiums" from their employees by receiving the value of their labor. *Id.* at 54a-55a. Based on this two-step transfigurement of plan benefits into labor premiums constructively received by insurance agents, the court held that "the *entire cost of an employee benefit plan*, whether paid from the employer's funds or financed by deductions from the salaries of employees, *is taxable as gross premiums* inuring to the benefit of the insurer." *Id.* at 55a (emphasis added). By focusing on the cost of the plan rather than on the cost of the insurance purchased by the plan, the court upheld a tax on "insurance" that has no correlation to the degree or kind of insurance coverage actually purchased by the plan.

Following the California Supreme Court's decision, respondents issued a statement declaring their intention to interpret it as "broadly" authorizing the taxation of "payments made with employer funds" regardless of the particular characteristics of the insurance coverage purchased by the plan. Clerk's Record 18 at 108 (Insurance Bulletin No. 83-51, August 31, 1983). Indeed, respondents have applied the California Supreme Court's decision so as to assess benefits paid out, not only from all single-employer plans with any form of excess-risk insurance, but from multiemployer Taft-Hartley trust funds as well. *See* Appendix at 65a.

C. The Lower Courts' Decisions

GMC and the Red Cross,[3] in their capacities as plan sponsors and fiduciaries of ERISA welfare benefit plans insured through an excess-risk arrangement, brought suit in federal court claiming that section 514 of ERISA preempts California's inclusion of plan benefits in the amount subject to its "gross premiums" tax.[4] The District Court agreed, rejecting the State's assertion that it sought simply to tax the business of insurance:

> Defendants characterize the gross premium tax as an assessment against Metropolitan for doing business in California. *Yet, in fact, it is the amount which is paid out by the plaintiffs below the trigger point which is being treated as a premium received by Metropolitan and is being taxed.* Under ERISA this taxation practice is preempted because it "relates to" or bears some connection or

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[3] The trustees of the Motion Picture Health and Welfare Fund, a multiemployer Taft-Hartley fund, also joined in the suit, but were dismissed for lack of standing because the State had not yet actually sought to tax their fund's benefits. *See* Appendix at 28a. However, immediately following the District Court's ruling in favor of GMC and the Red Cross, the State proceeded to tax the Motion Picture Fund's benefits and the benefits of all plans except those of GMC and the Red Cross. The trustees in turn, with their standing thus secured, brought a second action, on behalf of themselves and a class of employee benefit plans, which the Court of Appeals has now dismissed in light of its decision below. *See* Appendix at 64a.

[4] Sections 502(e)(1) and 502(a)(3) of ERISA, 29 U.S.C. §§ 1132(e)(1) & (a)(3), grant exclusive jurisdiction to the federal district courts to resolve suits brought by plan fiduciaries to enjoin conduct preempted by section 514 of ERISA.

> reference to the plans by using the plans' payments as a means for measuring taxable premiums. *The defendants are indirectly taxing benefit payments and they are impeding the discretion of plan sponsors to fund their plan guarantees through a combination of general assets and excess risk insurance.*

Appendix at 32a (emphasis added).

The Court of Appeals did not disagree with the District Court's findings or the conclusion that the tax "relates to" plans through the "explicit use of plan payments in calculating the tax." Appendix at 12a. It concluded, however, that the tax was saved from preemption as one which "regulates insurance" because it is "intimately associated" with the business of insurance. *Id.* at 13a. Beyond the legal incidence of the tax, however, the Court of Appeals supported its "intimate association" conclusion solely by accepting the State's position that plan benefits reflect a taxable "cost" of insurance *regardless of the amount actually paid by the plan to purchase the insurance*:[5]

> Here, the premium paid the insurer includes only the loading element, so a method

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[5] The Court of Appeals found that the insurance arrangements in *Moore v. Provident Life & Accident Insurance Co.*, 786 F.2d 922 (9th Cir. 1986), and *United Food & Commercial Workers v. Pacyga*, 801 F.2d 1157 (9th Cir. 1986), were both "similar to those in the case before us." Appendix at 14a. Both *Moore* and *Pacyga* hold that plans which purchase excess-risk policies remain largely "self-insured" or "uninsured." *Moore*, 786 F.2d at 927; *Pacyga*, 801 F.2d at 1162. The court below thus implicitly held that, once a plan purchases any level of insurance, the degree to which the plan is "insured" or "self-insured" does not determine the degree to which its benefits can be taxed.

> for determining the dollar amount of the net premium element is necessary [*i.e.*, to retain the same tax base as under a "full insurance" policy where both "elements" are paid to the insurer]. As the benefits paid by the plans equal the net premium under a traditional policy [*i.e.*, but not under the excess-risk policies at issue], appellants have referred to those payments in calculating the tax. *This reference . . . is used to measure the cost of insurance provided accurately* . . . .

Appendix at 13a (emphasis added). What the Court of Appeals' opinion never identifies is the subject of the clause "insurance provided." As the California Supreme Court itself acknowledged, the tax does not seek to measure only the cost of the insurance provided *by the insurer* to the plan, but also the imputed cost of the "insurance" [*i.e.*, benefits] provided *by the plan* to employees. It is this "entire cost of an employee benefit plan" rather than the cost of purchasing insurance that the tax seeks to measure "accurately." Appendix at 55a.

If a law purporting to "regulate insurance" treats a plan as an "insurer" or as "engaged in the business of insurance," then section 514(b)(2)(B) (the "deemer clause") overrides the insurance saving clause and reasserts federal preemption. Although the Court of Appeals acknowledged that the deemer clause is the "final step" in the preemption analysis, it found that the legal incidence of the tax foreclosed any inquiry into whether California's treatment of plan sponsors as "mere agents" of insurance companies, plan benefits as synonymous with insurance "premiums," and benefit-providing cost of a plan as equivalent to the

cost of "insurance" effectively deemed the plan to be an "insurer" or "engaged in the business of insurance":

> The tax at issue does not run afoul of the deemer clause. It is imposed on insurance companies, not benefit plans. It may affect benefit plans, but effects are not determinative. *Metropolitan* so holds. *Metropolitan* left intact a mandated-benefit law that had significant effects on Massachusetts plans. *In so doing, it indicated that state laws affecting benefit plans may escape preemption if they fall directly on insurance companies, as the tax at issue does.*

Appendix at 14a (emphasis added). GMC and the Red Cross here petition this Court to address whether it intended the *Metropolitan* decision to so broaden ERISA's saving clause and to so narrow its deemer clause as to permit the states to tax benefits paid out by ERISA plans as long as the legal incidence of the tax—though not its purpose or effect—falls on an insurance company.

REASONS TO GRANT THE WRIT

The decision of the Court of Appeals invites the states to dismantle the wall Congress explicitly sought to construct between plan benefits and the states' taxing power. *See, e.g.*, 29 U.S.C. § 1144(b)(5)(B)(i) (specifically referring to preemption of "any State *tax law* relating to employee benefit plans"); H.R. Rep. No. 655, Part I, 98th Cong., 2d Sess. 42 (1984) ("the Committee reasserts that a state *tax levy* on employee welfare benefit plans is preempted by ERISA"). Indeed, state taxation relating to employee benefit plans

poses a far more direct threat to those plans than state regulation. Whereas state regulation typically threatens to add only marginally to the administrative costs of maintaining the plan, state taxation directly decreases the funds otherwise available for providing health and pension benefits to employees and their dependents. Such state exactions from plan assets are contrary to the policy embedded at the core of ERISA preemption and are antithetical to the federal government's specific policy of exempting plan assets from its own taxing power.

Moreover, the tax at issue not only decreases amounts available for benefits, but also, as the District Court found, impedes the discretion ERISA grants plan sponsors in the selection of insurance arrangements that respond to a plan's need for coverage only in the event benefit claims exceed anticipated levels.[6] By upholding the imposition of a tax on the "entire cost" of a plan whenever it purchases any margin of insurance protection, the decision below encourages plans to forego that protection and thereby place at risk their ability to respond to unanticipated and perhaps catastrophic claim experience.

California is not alone in confronting plans with this funding dilemma of whether to purchase excess-risk insurance and thereby render all benefits subject to tax, or whether to sever all ties with insurance companies and thereby risk incurring uninsured cat-

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[6] Section 3(1) of ERISA, 29 U.S.C. § 1002(1), defines an "employee welfare benefit plan" as a program to provide certain listed kinds of benefits "through the purchase of insurance or otherwise."

astrophic losses. Texas has recently adopted California's benefit-as-premium theory.[7] There is no reason to believe that other states will not follow now that the Court of Appeals has sanctioned the indirect taxation of benefits. Moreover, the Court of Appeals' logic is not confined to any particular kind of plan insurance arrangement. Indeed, since the benefits themselves are deemed to entail an intrinsic cost of "insurance" taxable by the states so long as the legal incidence of the tax falls elsewhere, even plans that contract with insurance companies solely for administrative services may be vulnerable.[8]

It is not only the particular result the Court of Appeals reaches that is injurious to the federal interest, but also its far-reaching misconstruction of section 514. In a series of decisions, this Court has carefully interpreted the "statutory complexity" of ERISA's express preemption provision so as to affirm Congress's fundamental intent to preempt broadly any state law that "has some connection with or reference to" an employee benefit plan, unless that law can be said to "regulate insurance" within a "narrow," "common-sense understanding" of the term. *See Pilot Life Insurance Co. v. Dedeaux*, 107 S. Ct. 1549, 1554 (1987); *see also Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985) (state laws regulating content of insurance product "regulate insurance" within "common-sense view of the matter");

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[7] 1987 Tex. Gen. Laws, 70th Leg., 2d C.S., ch. 5, art. 8, at 57.

[8] The saving clause also protects state laws which "regulate . . . banking, or securities." Thus, if the Court of Appeals' approach were upheld, then the states would have an array of intermediaries through which to pass their benefit-based taxes.

Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 104 (1983) (section 514 combines an "all-inclusive pre-emption provision" with the "enumeration of narrow, specific exceptions").

The Court of Appeals, in contrast, employed the complexity of section 514 to frustrate rather than to further Congress' intent. As this Court has specifically recognized, "ERISA's authors clearly meant to preclude the States from avoiding through form the substance of the pre-emption provision." *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981). Here, however, the Court of Appeals permitted form to override the practical effects of a tax calculated with *necessary* reference to welfare plan benefits. The legal incidence of the tax does not alter the reality that California is taxing plan benefit activity and thereby imposing unrestrained economic burdens on plans that are indistinguishable from those which would result from direct taxation.[9] *See American Bank & Trust Co. v. Dallas County*, 463 U.S. 855, 862 (1983) (State "tax is barred regardless of its *form* if federal obligations must be considered, either directly or indirectly, in *computing* the tax" because "practical impact of such a tax is indistinguishable from that of a tax imposed directly . . . .") (emphasis in original); *Ramah Navajo School Board v. Bureau of Revenue*,

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[9] California estimated to the District Court that it alone stood to gain over $10 million a year from the benefit tax. Clerk's Record 14 at 2. Since the insurance companies naturally pass the benefit-related taxes directly through to the plans, the District Court found that California is, in economic effect, "indirectly taxing benefit payments." Appendix at 32a. The Court of Appeals did not disagree with that finding, but apparently found it irrelevant.

458 U.S. 832, 845 (1982) (regardless of the "legal incidence" of the tax, the tax is preempted because it " 'stands as an obstacle to the accomplishment of the full purposes and objectives of Congress' ").

Notwithstanding the Court of Appeals' assertions to the contrary, this Court's decision in *Metropolitan* is not controlling. The *Metropolitan* case simply held that a state law mandating a type of coverage in all group insurance policies, including those purchased by ERISA plans, is a law which "regulates insurance" within the meaning of the saving clause. The Court reached that conclusion after extensively examining the language, structure, and legislative history of section 514, as well as an analogous body of precedent defining—as a matter of federal law—the related phrase "business of insurance" in the McCarran-Ferguson Act. 15 U.S.C. § 1011 *et seq.* The Court of Appeals found, however, without any examination of the factors addressed in *Metropolitan*, that the saving clause preserves any state law that has an "intimate association" with the business of insurance, and, most critically, that the states themselves are free to create that association by deeming plan benefits to be "insurance premiums" intrinsically mirroring a taxable cost of "insurance."

This Court should not wait for a conflict to develop among the Courts of Appeals before recognizing, as in *Pilot Life*, the necessity to clarify the boundaries of the saving clause, particularly insofar as they are formed by the deemer clause. The Court of Appeals' wooden notion that the deemer clause is inapplicable whenever the state law is formally imposed on an insurance company, conjoined with its expansive deference to California's inventive equation of plan ben-

efits with "insurance premiums," provides the states with a blueprint for the evisceration of section 514. Moreover, employee benefit plans stand to suffer irreparable harm until this Court acts. In addition to the threat of uninsured losses confronting plans that abandon excess-risk coverage in the wake of the decision below, plan sponsors stand to forfeit permanently all amounts collected by the states prior to this Court's review because they have no avenue through which to pursue a refund. ERISA requires that plan sponsors bring their preemption challenges exclusively to federal court.[10] 29 U.S.C. § 1132(e)(1). The Eleventh Amendment, however, precludes those courts from ordering the states or their officials to refund any tax amounts they succeed in collecting. *See, e.g., Edelman v. Jordan*, 415 U.S. 651 (1974). The Court of Appeals' decision, though wrong, will make it difficult in states outside the circuit and impossible in those within it to secure preliminary injunctive relief. Accordingly, only action by this Court can forestall the irrevocable damage the decision of the Court of Appeals will otherwise inflict on benefit plans and benefit policy.

CONCLUSION

Petitioners do not challenge the power of the states to tax insurance companies even though the costs of the tax are passed through by the insurer to an ERISA plan. What they challenge is the power of the states to tax benefits paid out by ERISA plans under

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[10] Respondents concede that plan sponsors have no standing to pursue refund actions in state court and that they thus must rely completely on the ability and willingness of their insurers to undertake such an action.

the theory that such benefits constitute insurance premiums. Such taxation poses a far greater threat to the policy embodied in section 514 than any of the states' attempts to regulate plans previously examined by this Court. Both the result at issue and the reasoning invoked to reach it profoundly undermine the congressional will this Court has painstakingly identified and furthered in decisions from *Alessi* to *Pilot Life*. Petitioners accordingly respectfully ask that this Petition be granted and that the issues raised herein be set for the full consideration they deserve.

December 14, 1987

Respectfully submitted,

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APPENDIX

APPENDIX A

The American National Red Cross has no subsidiaries or affiliates. General Motors Corporation's non-wholly-owned subsidiaries and affiliates are as follows:

Aralmex, S.A. de C.V. (Mexico)
Automotriz Gencor, S.A. (Ecuador)
Autos y Maquinas del Ecuador, S.A. (AYMESA) (Ecuador)
Comanis Nacional de Direcciones Automotrices, S.A. de C.V. (Mexico)
Compresores Delfa, C.A. (Venezuela)
Convesco Vehicle Sales GmbH (West Germany)
Daewoo Motor Co., Ltd. (Korea)
DHB-Componentes Automotives, S.A. (Brazil)
Fabrica Columbians de Automotores, S.A. ("Colomotores") (Colombia)
General Motors de Colombia, S.A. (Colombia)
General Motors Egypt, S.A.E. (Egypt)
General Motors Iran Limited (Iran)
General Motors Kenya Limited (Kenya)
GM Allison Japan Limited (Japan)
GM Fanuc Robotics Corp. (USA)
Industries Mecaniques Meghrebires, S.A. (Tunisia)
Industrija Delova Automobils, Kikinda (Yugoslavia)
Isuzu Motors Limited (Japan)
Isuzu Motors Overseas Distribution Corp. (Japan)
Kabelwerke Reinshagen GmbH (West Germany)
Kabelwerke Reinshagen Werk Berlin GmbH (West Germany)
Kabelwerke Reinshagen Werk Neumarkt GmbH (West Germany)
Moto Diesel Mexicana, S.A. de C.V. (Mexico)
Motor Enterprises, Inc. (USA)
Omnibus BB Transportes, S.A. (Ecuador)

Promotorade Partes Electronicos Automotrices (Mexico)
P.T. Mesin Isuzu Indonesia (Indonesia)
Senalizacion y Accessorios del Automobile Yorka, S.A. (Spain)
Unicables, S.A. (Spain)

APPENDIX B

UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

GENERAL MOTORS CORPORATION; AMERICAN NATIONAL RED CROSS; JASPER BALLANCE; et al.,
Plaintiffs-Appellees,

v.

CALIFORNIA STATE BOARD OF EQUALIZATION; WILLIAM M. BENNET; CONWAY H. COLLIS; ERNEST J. DRONENBURG, JR.; RICHARD NEVINS; GRAY DAVIS*; and BRUCE BUNNER,
Defendants-Appellants.

No. 85-5618
D.C. No. CV-83-6801-DWW
OPINION

Argued and Submitted
February 5, 1986—Pasadena, California

Filed April 29, 1987

Before: Anthony M. Kennedy, Otto R. Skopil, Jr. and Arthur L. Alarcon, Circuit Judges.

Opinion by Judge Kennedy

Appeal from the United States District Court
for the Central District of California
David W. Williams, Senior District Judge, Presiding

*Substituted for Kenneth Cory, pursuant to Fed. R. App. P. 43(c)(1).

SUMMARY

Taxation

Appeal from a grant of summary judgment against a state taxing authority. Reversed.

The appellants, the California State Board of Equalization (State Board) and its individual members, administer a tax on gross premiums received by insurance companies doing business in the state. The appellees, including General Motors Corporation (and collectively referred to as GM), are fiduciaries of employee welfare benefit plans within the meaning of the Employee Retirement Income and Security Act of 1974 (ERISA), and fund plans providing disability and health care benefits with company assets and excess-risk policies from Metropolitan Life Insurance Company. By paying some of the claims themselves, and depending on excess risk policies for larger risks, the premiums paid Metropolitan were lower than under a traditional arrangement whereby larger premiums are paid and the insurance company pays all claims. In calculating the gross premiums tax assessed against Metropolitan, the appellants included premiums paid by the appellees to Metropolitan, plus benefits paid directly to employees under the plans. This method of calculation was upheld by the California Supreme Court. Appellee's contracts require that Metropolitan be reimbursed for premium taxes paid, so plaintiffs brought an action in federal court, seeking declaratory and injunctive relief, arguing that appellants' interpretation of the term "gross premiums ... received" was preempted by ERISA. The court granted appellees' motion for summary judgment.

[1] GM satisfies the requirements for standing, as they will have to pay the insurance company money they would not otherwise have to pay, and their injury is directly attributable to the tax, and would be fully redressed if the taxation were

enjoined. [2] Cases cited by the State Board do not defeat standing, as they lack either an allegation that the appellee's own rights have been violated or an express grant of standing. [3] The Tax Injunction Act applies only when a party has a plain, speedy and efficient remedy in state court. Since there is no state court remedy for GM in this case, and only Metropolitan can challenge the tax, the Tax Injunction Act does not apply. [4] Abstention is not proper in this case, since the preemption issue is one of federal law, [5] nor does the Eleventh Amendment preclude an award of injunctive relief.

[6] The district court's holding that ERISA preempts a premiums tax assessed against an insurer and calculated with reference to benefits paid by ERISA plans is reviewed de novo and reversed. [7] The Supreme Court has emphasized the broad scope of ERISA's preemption clause, [8] and though the clause is not all encompassing, the explicit use of plan payments in calculating the tax brings the preemption clause into play. [9] But the second step in the preemption analysis involves the insurance saving clause, which provides that any state law that regulates insurance, banking or securities shall remain in force. This clause must be interpreted broadly, [10] and must be construed to cover taxation of insurance. [11] The savings clause preserves the tax at issue, because the tax is intimately associated with the business of insurance. [12] Although the tax is calculated with reference to benefit payments, the payments are used only as a means of capturing the total cost of the insurance provided, the amount of which the State Board seeks to reach. [13] The final step in preemption analysis requires consideration of the deemer clause, which prevents a benefit plan being deemed to be an insurance company to prevent states from regulating benefit plans simply because they provide insurance. [14] But the tax here is imposed on the insurance companies, not the benefit plans.

COUNSEL

William J. Kilberg, Washington, D.C., for the plaintiffs-appellees.

Patti S. Kitching, Los Angeles, California, for the defendants-appellants.

Benjamin W. Boley, James R. Bieke, William R. Hanlon, Washington, D.C., for the amicus curiae.

OPINION

KENNEDY, Circuit Judge:

Appellants, the California State Board of Equalization, board members, and various state officials, appeal the district court's grant of summary judgment in favor of appellees, General Motors Corporation and the American National Red Cross. We reverse.

Appellees are fiduciaries of "employee welfare benefit plans" within the meaning of section 3(1) of the Employee Retirement Income and Security Act of 1974 (ERISA), 29 U.S.C. § 1002(1) (1982). They fund the plans, which provide disability and health care benefits, with company assets and excess-risk policies from Metropolitan Life Insurance Company. Under these policies, appellees are responsible for paying all claims up to a trigger point, an aggregate level of claims specified annually, while Metropolitan is responsible for paying all claims above that point.

Appellees adopted the excess risk policies to replace traditional policies under which Metropolitan received larger premiums and paid all claims. It appears that appellees did so to retain use of their funds until claims were actually paid and to reduce premiums tax liability for their insurer.

Appellants administer a tax on "gross premiums ... received" by insurance companies doing business in California. Cal. Const. art. XIII, § 28(c); Cal. Rev. & Tax Code

§§ 12201, 12221 (West 1970 & Supp. 1986). In calculating "gross premiums . . . received" by Metropolitan, appellants included premiums appellees paid Metropolitan plus benefits appellees paid employees under their plans. As a matter of state law, the California Supreme Court upheld this method of calculation in *Metropolitan Life Ins. Co. v. State Bd. of Equalization*, 32 Cal. 3d 649, 652 P.2d 426, 186 Cal. Rptr. 578 (1982).

Appellees' insurance contracts require them to reimburse Metropolitan for premium taxes incurred as a result of their plans. After learning of the California Supreme Court decision, they brought the instant action in federal court, seeking declaratory and injunctive relief. They argued that appellants' interpretation of "gross premiums . . . received," though valid as a matter of state law, was preempted by ERISA.[1] The district court granted appellees' motion for summary judgment. It enjoined appellants from calculating "gross premiums . . . received" with reference to benefits paid by the plans. *General Motors Corp. v. California State Bd. of Equalization*, 600 F. Supp. 76 (C.D. Cal. 1984) (original opinion, amended in unpublished order). This appeal followed.

Ultimately, we must determine whether ERISA preempts a premiums tax assessed against an insurer and calculated with reference to benefits paid by ERISA plans. Before we reach that issue, however, we must resolve various procedural challenges.

We first consider whether appellees have standing to bring this action. In order to satisfy the requirements for standing, appellees must allege injury that is "distinct and palpable," *Warth v. Seldin*, 422 U.S. 490, 501 (1975), and not "abstract," "conjectural," or "hypothetical," *City of Los Angeles v. Lyons*,

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[1]The preemption issue played no part in the California Supreme Court case because that case involved the taxable years 1967-69 and ERISA was not enacted until 1974.

461 U.S. 95, 101-02 (1983). The injury must be "fairly traceable to the defendant's allegedly unlawful conduct and likely to be redressed by the requested relief." *Allen v. Wright*, 468 U.S. 737, 751 (1984).

[1] Appellees satisfy these requirements. As a result of the taxation they allege to be unlawful, and their contract with Metropolitan, appellees will have to pay the insurance company substantial sums for which they would otherwise not be liable. Such real economic injuries have long been recognized as sufficient basis for standing. *See Sierra Club v. Morton*, 405 U.S. 727, 733 (1972). In addition, their injury is directly attributable to appellants' allegedly unlawful taxation, and would be fully redressed were the taxation enjoined. *See Wright*, 468 U.S. at 757-58 (discussing "fairly traceable" component of standing requirement); *Simon v. Eastern Kentucky Welfare Rights Org.*, 426 U.S. 26, 45-46 (1976) (discussing "redressibility" component of standing requirement).

This is not a case, moreover, in which appellees seek to assert rights of Metropolitan rather than rights of their own. They do not bring this action as bystanders affected by alleged violations of Metropolitan's rights, but as fiduciaries of employee benefit plans, who seek to vindicate rights ERISA grants in express terms.[2]

[2] The cases on which appellants rely to show that standing is lacking are readily distinguishable. In those cases, either an allegation that the plaintiff's own rights have been violated or an express grant of standing is absent. In *EMI Ltd. v. Bennett*, 738 F.2d 994 (9th Cir.) (*EMI II*), *cert. denied*, 469 U.S. 1073 (1984), we dismissed a parent corporation's action because the parent alleged injury flowing from violations of its subsid-

[2]These rights are contained in section 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3) (1982), which allows fiduciaries to bring a civil action to enjoin violations of the Act's provisions, including the preemption provisions at issue.

iary's rights, not its own. *Id.* at 996-98. *Cf. Alcan Aluminum, Ltd. v. Dep't of Revenue*, 724 F.2d 1294, 1299 (7th Cir. 1984) (standing exists where parent alleges violation of its own rights). And in *Fentron Indus. v. Nat'l Shopmen Pension Fund*, 674 F.2d 1300 (9th Cir. 1982), we questioned an employer's standing because ERISA does not expressly grant employers the right to sue. *Id.* at 1305 n.5. In the case before us, in which both the appropriate allegation and the express grant are present, appellees have standing to proceed with their suit.

We next consider whether the Tax Injunction Act bars this action. The Tax Injunction Act, 28 U.S.C. § 1341 (1982), provides that "district courts shall not enjoin, suspend or restrain the assessment, levy or collection of any tax under state law where a plain, speedy and efficient remedy may be had in the courts of such state." *Id.* To obtain the relief they seek, therefore, appellees must show that their suit is not covered by this prohibition.

Appellees cannot maintain that ERISA is an exception to the Tax Injunction Act. The Supreme Court left that issue open in *Franchise Tax Bd. v. Constr. Laborers Vacation Trust*, 463 U.S. 1, 20 & n.21 (1983), but we resolved it in *Ashton v. Cory*, 780 F.2d 816, 821-22 (9th Cir. 1986), which holds that ERISA actions are subject to the Tax Injunction Act.

[3] In this case, however, the Tax Injunction Act is inapplicable by its own terms. The Act applies only when a party has a "plain, speedy and efficient" remedy in state court. As appellants concede, appellees have no remedy in state court. Under California law, only the party against whom a tax is assessed, in this case Metropolitan, may challenge the tax. Cal. Const. art. XIII, § 32; Cal. Rev. & Tax Code §§ 13101, 13108 (West 1970 & Supp. 1986).

Appellants' contention that Metropolitan's ability to challenge the tax constitutes a "plain, speedy and efficient" rem-

edy for appellees is unpersuasive. It is true that Metropolitan's interests are substantially similar to that of the appellees. *Capitol Industries-EMI, Inc. v. Bennett*, 681 F.2d 1107 (9th Cir.) (*EMI I*), *cert. denied*, 459 U.S. 1087 (1982), squarely holds, however, that a party without state administrative or judicial remedies can maintain a federal action even if a taxpayer with substantially the same interests has state remedies. *Id.* at 1119. The Tax Injunction Act is no bar to appellees' suit.

[4] We next consider whether abstention would be proper in this case. The preemption issue is one of federal law, *Marshall v. Chase Manhattan Bank, N.A.*, 558 F.2d 680, 683 (2d Cir. 1977), and the suit by appellees is one over which the federal courts exercise exclusive jurisdiction, 29 U.S.C. § 1132(e)(1)). Under these circumstances, abstention would be inappropriate. *See Colorado River Water Conservation Dist. v. United States*, 424 U.S. 800, 813-20 (1976) (discussing circumstances where abstention is appropriate); *Silberkleit v. Kantrowitz*, 713 F.2d 433, 436 (9th Cir. 1983) (declining to abstain where "exclusively federal claims" are present).

[5] We last consider whether the eleventh amendment precludes an award of injunctive relief in this case. The eleventh amendment does not bar actions for injunctive relief against individual state officials, but it does bar such actions against the state or its agencies, absent their consent. *Alabama v. Pugh*, 438 U.S. 781 (1978) (per curiam). As to the individual appellants, therefore, the district court's injunction may be permissible; but as to appellant Board, a state agency, the injunction must be vacated and the case dismissed. *See V.O. Motors, Inc. v. California State Bd. of Equalization*, 691 F.2d 871 (9th Cir. 1982) (dismissing suit for injunctive relief against appellant Board on eleventh amendment grounds).

[6] Having resolved the procedural matters before us, we address the merits of the case. We must determine whether ERISA preempts a premiums tax assessed against an insurer

and calculated with reference to benefits paid by ERISA plans. The district court held that ERISA preempted such a tax. *General Motors*, 600 F. Supp. at 80. We review that holding de novo, *United States v. McConney*, 728 F.2d 1195, 1201 (9th Cir.) (en banc), *cert. denied*, 469 U.S. 824 (1984), and reverse.

The framework for analysis of ERISA preemption claims is well established. *See, e.g., Moore v. Provident Life & Accident Ins. Co.*, 786 F.2d 922, 926 (9th Cir. 1986). The first step in the analysis is to determine whether the state law at issue "relate[s] to" employee benefit plans, thereby invoking ERISA's preemption clause, 29 U.S.C. § 1144(a). *Moore*, 786 F.2d at 926.

[7] The Supreme Court has repeatedly emphasized the broad scope of the preemption clause. *Metropolitan Life Ins. Co. v. Massachusetts*, 105 S. Ct. 2380, 2389 (1985); *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 97 (1983); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981). In its most recent pronouncement on the subject, the Court stated that the phrase "relate[s] to" is to be given "its broad common-sense meaning, such that a state law 'relate[s] to' a benefit plan 'in the normal sense of the phrase, if it has a connection with or reference to such a plan.' " *Metropolitan*, 105 S. Ct. at 2389 (quoting *Shaw*, 463 U.S. at 97).

The Court's broad reading of the preemption clause leads us to conclude that the tax at issue "relate[s] to" benefit plans. The tax is computed on the basis of benefits paid by the plans; reference to plan activities in computing the tax is unavoidable. In its broadest sense, therefore, ERISA applies, and further analysis is required.

[8] We recognize that the preemption clause is not all encompassing, *Martori Bros. Distrib. v. James-Massengale*, 781 F.2d 1349, 1356 (9th Cir. 1986), and that state laws may affect benefit plans in "too tenuous, remote, or peripheral a

manner" to justify preemption, *Shaw*, 463 U.S. at 100 n.21. Nevertheless, we conclude that the explicit use of plan payments in calculating the tax satisfies the modest requirements for bringing the clause into play. *Cf. Firestone Tire & Rubber Co. v. Neusser*, 810 F.2d 550 (6th Cir. 1987) (municipal income tax, applied without reference to plans, does not invoke preemption clause).

We also recognize that "governmental plans," as defined in ERISA, are not entitled to the protection of the preemption clause. 29 U.S.C. § 1003(b)(1) (1982). The Pension Benefit Guaranty Corporation (PBGC), however, has ruled that the Red Cross plan is not excluded from coverage as a "governmental plan." The conclusions of the PBGC are entitled to "great deference," *Connolly v. Pension Benefit Guar. Corp.*, 581 F.2d 729, 730 (9th Cir. 1978), *cert. denied*, 440 U.S. 935 (1979), and its rulings must stand unless there are "compelling indications" that they are incorrect, *Paden v. United States Dep't of Labor*, 562 F.2d 470, 473 (7th Cir. 1977). No such indications are present here, leading us to conclude that the Red Cross plan is entitled to the protection of the preemption clause.

[9] The second step in the preemption analysis involves the insurance saving clause, which provides that any state law that "regulates insurance, banking, or securities" shall remain in force. 29 U.S.C. § 1144(b)(2)(a). This clause must be construed broadly, with due regard for the states' traditional powers in the field of insurance. *Metropolitan*, 105 S. Ct. at 2389. Such a construction will undoubtedly return to the states much of the authority the preemption clause has taken away, but that result follows from the statutory language, which we are bound to apply. *See id.*

[10] The saving clause must also be construed to cover taxation of insurance. The clause preserves the McCarran-Ferguson Act's reservation of the business of insurance to the states. *Metropolitan*, 105 S. Ct. at 2392 n.21. McCarran-

Ferguson, in turn, preserves the states' ability to "tax and regulate" insurance. *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 218 (1979). Thus taxation of insurance, no less than regulation, may fall within the saving clause.

[11] Given this background, we hold that the saving clause preserves the tax at issue, for the tax is intimately associated with the business of insurance. It is imposed on insurers, as a result of their participation in the insurance business in California. And it is calculated in terms of premiums, the traditional mode of payment for insurance services.

[12] Concededly, the tax is calculated with reference to benefit payments. The payments, however, are used only as a means of capturing the total cost of the insurance provided, the amount which appellants' premiums tax seeks to reach. *Metropolitan Life Ins. Co. v. State Bd. of Equalization*, 32 Cal. 3d 649, 660, 652 P.2d 426, 186 Cal. Rptr. 578 (1982). Total cost has two elements, the net premium and the loading. The net premium is the amount which, invested properly, will yield a fund sufficient to pay expected claims. The loading is the amount added to the net premium to cover the insurer's administrative costs and compensate it for assuming the risk that claims will exceed expected levels. *Allstate Ins. Co. v. State Bd. of Equalization*, 169 Cal. App. 2d 165, 168, 336 P.2d 961, 964 (1959). Under a traditional policy, both elements are included in the premium paid the insurer, making that premium an accurate measure of the total cost of the insurance provided.

Here, the premium paid the insurer includes only the loading element, so a method for determining the dollar amount of the net premium element is necessary. As the benefits paid by the plans equal the net premium under a traditional policy, appellants have referred to those payments in calculating the tax. This reference, which is used to measure the cost of insurance provided accurately, does not deprive the tax of the pro-

tection of the saving clause, for the incidence of the tax remains on the insurer, not the plans.

Elevating the incidence of the tax over the effects may be somewhat formalistic. It is, nevertheless, a familiar method of analysis in the field of taxation. *See Flint v. Stone Tracy Co.*, 220 U.S. 107 (1911) (tax on corporate franchise valid even though effect is to reach income exempt from taxation). Perhaps more importantly, it is the method *Metropolitan* requires us to employ in cases of this sort.

[13] The final step in the preemption analysis requires consideration of the deemer clause, which provides that no benefit plan "shall be deemed to be an insurance company . . . or to be engaged in the business of insurance . . . for purposes of any law of any state purporting to regulate insurance companies . . . ." 29 U.S.C. § 1144(b)(2)(B) (1982). The precise scope of this clause remains unclear. At base, however, it appears to prevent states from regulating benefit plans simply because they provide insurance for covered employees. *See Wadsworth v. Whaland*, 562 F.2d 70, 77 (1st Cir. 1977), *cert. denied*, 435 U.S. 980 (1978); *Eversole v. Metropolitan Life Ins. Co.*, 500 F. Supp. 1162, 1169 (C.D. Cal. 1980).

[14] The tax at issue does not run afoul of the deemer clause. It is imposed on insurance companies, not benefit plans. It may affect benefit plans, but effects are not determinative. *Metropolitan* so holds. *Metropolitan* left intact a mandated-benefit law that had significant effects on Massachusetts plans. In so doing, it indicated that state laws affecting benefit plans may escape preemption if they fall directly on insurance companies, as the tax at issue does.

Moore v. Provident Life & Accident Ins. Co., 786 F.2d 922 (9th Cir. 1986), and *United Food and Commercial Workers v. Pacyga*, 801 F.2d 1157 (9th Cir. 1986), are not to the contrary. Both involve insurance policies similar to those in the case before us. However, both also find the saving clause

inapplicable, presumably because insurance is not involved in any meaningful sense in either case. *Moore*, 786 F.2d at 927; *Pacyga*, 801 F.2d at 1159. Here, in contrast, the saving clause is fully applicable, leaving the tax in force.

REVERSED.

APPENDIX C

UNITED STATES DISTRICT COURT FOR THE CENTRAL DISTRICT OF CALIFORNIA

GENERAL MOTORS CORPORATION, *et al.*,

Plaintiffs,

v.

CALIFORNIA STATE BOARD OF EQUALIZATION, *et al.*,

Defendants.

No. CV 83-6801-DWW(KX)

Employee benefit plan fiduciaries brought action against California State Board of Equalization and others for declaratory, injunctive, and remedial relief in connection with insurance franchise taxes imposed. Defendants moved for judgment on the pleadings. The District Court, David W. Williams, Senior District Judge, held that: (1) to extent that state had in fact imposed insurance franchise taxes against employee benefit plan excess risk insurer based on gross premiums, fiduciaries of those plans had standing under ERISA to challenge the action; (2) ERISA is outside scope of prohibition against construing any federal law so as to impair or invalidate state law regulating insurance; and (3) by imposing an insurance franchise tax on gross premiums received by excess risk insurers in connection with employee benefit plan fiduciaries' retention of responsibility for payment of all benefits from the respective plans below a trigger point, state indirectly taxed those benefit payments and impeded the fiduciaries' funding discretion, in violation of ERISA preemption.

Motion granted in part and denied in part.

Stephen E. Tallent, Wayne A. Schrader, Gibson, Dunn & Crutcher, Los Angeles, Cal., for plaintiffs; William J. Kilberg, Paul D. Inman, Gibson, Dunn & Crutcher, Washington, D.C., of counsel.

John K. Van de Kamp, Atty. Gen. of the State of Cal., Edmond B. Mamer, Patti S. Kitching, Deputy Attys. Gen., Los Angeles, Cal., for defendants.

ORDER

DAVID W. WILLIAMS, Senior District Judge.

Plaintiffs, General Motors Corporation ("GMC") and the American National Red Cross ("Red Cross"), in their capacities as sponsoring employers and administrators of certain employee disability and health care plans established pursuant to collective bargaining agreements, and current trustees of the Motion Picture Health and Welfare Fund (MPF"), are suing defendants, The California State Board of Equalization ("Board"), Board members, and certain state officials, for declaratory, injunctive, and remedial relief.

Both GMC and Red Cross entered into excess risk arrangements with the Metropolitan Life Insurance Company ("Metropolitan") providing that they would remain responsible for payments of all benefits from their respective plans below a trigger point. This trigger point was to be established annually based on a projected level of aggregate benefit payments. Local GMC units were to maintain claim records and evaluate and pay claims below the trigger amount for sickness and accident coverage. Metropolitan would perform these functions for other forms of coverage. The funds used to pay the pretrigger claims are

drawn from GMC accounts. Similarly, the funds used to pay pretrigger claims for Red Cross are drawn by Metropolitan from a Red Cross account, and Metropolitan is authorized to draw on that account only to satisfy pretrigger claims.

Defendants levied taxes upon Metropolitan on benefits paid out of the GMC Disability Trusts, the GMC Plan, and the Red Cross Plan. As Metropolitan was indemnified by GMC and Red Cross for the tax payments, these costs were passed onto them.

The MPF entered into an excess risk arrangement with the Union Labor Life Insurance Company ("Union Labor") whereby MPF assumed the risk of paying benefits up to a defined trigger point. A year or so later the trustees of the fund resolved to terminate their excess risk policies and become completely self-insured with respect to those components covered by it. MPF now believes defendants will levy a tax on benefits paid out during the year in which the excess risk arrangement was in existence. It too has an existing indemnity agreement, so the MPF assumes it will incur the cost for the tax.

Plaintiffs bring this action because defendants' interpretation of "gross premiums" was upheld by the California Supreme Court in *Metropolitan Life Ins. Co. v. State Board of Equalization,* 32 Cal.3d 649, 186 Cal.Rptr. 578, 652 P.2d 426 (1982). In that action, for the years 1967–1969 Metropolitan was assessed an insurance franchise tax based upon the amount of Metropolitan's gross premiums. The Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq.,* was not at issue then, however, because the years involved were prior to ERISA's passage in 1974. Metropolitan has now raised that issue, and it has filed refund claims for the 1975–1982 years alleging that the franchise tax has been preempted by ERISA. These claims were denied, and Metropolitan has filed suit in San Francisco Superior Court.

The predominant legal issues raised in this action are this court's jurisdiction, the plaintiffs' standing to sue, the State of California's power to tax in the manner at issue here, and ERISA's possible preemptive effect. The courts have favored a broad interpretation of ERISA's preemptive provision. State taxation is not one of the enumerated exceptions to ERISA's preemptive reach. A recent ERISA amendment and relevant legislative history also indicate Congress' intent to preempt any state tax law which relates to employee benefit plans. Defendants' characterization of "gross premiums" in this context runs afoul of ERISA. Therefore, this court must rule that defendants' tax practice as described in this action is preempted by ERISA.

JURISDICTION AND STANDING

Jurisdiction is conferred upon this court through ERISA, 29 U.S.C. § 1132(a)(3) and (4). Plaintiffs are fiduciaries of employee welfare benefit plans. As such, they have a direct and explicit statutory basis for standing. Section 1132(a)(3) provides that a fiduciary may bring a civil action to enjoin any act or practice which violates any provisions of a plan's terms. A participant or beneficiary may bring an action to recover benefits under the terms of his plan in state court. Furthermore, defendants' interpretation of "gross premiums" and their assessment and collection orders based upon such an interpretation are "state action having effect of law." So, they are state laws within the meaning of ERISA's section 1144(c)(1).

Defendants contend that any injury suffered by plaintiffs results solely from plaintiffs' agreement with an insurance company to reimburse it for its tax payments. They cite *EMI Ltd. v. Bennett,* 738 F.2d 994 (9th Cir.1984) and *Shell Petroleum, N.V. v. Graves,* 709 F.2d 593 (9th Cir.1983) for the proposition that a third party who is not being taxed does not have standing to sue the taxing authority because his injury is neither direct, individual, distinct, nor

palpable. *See also Allen v. Wright,* — U.S. —, 104 S.Ct. 3315, 82 L.Ed.2d 556 (1984). Plaintiffs' jurisdictional and standing foundation, however, arises under ERISA provisions as they bring this action as plan fiduciaries seeking to preempt a practice that relates to their employee benefit plans. ERISA expressly empowers fiduciaries to seek relief in federal court against "any act or practice" which violates ERISA's provisions. 29 U.S.C. § 1132(a)(3) and (f).

Although MPF is also a fiduciary under ERISA, no indication has been given that defendants' actions have had an adverse effect upon its employee benefit plan. Unlike GMC and Red Cross, there is no tax deficiency to speak of which has been asserted against Union Labor, MPF's insurer. MPF can assert ERISA in defense of actions affecting its plan, but it cannot be allowed to do so when the alleged effect is speculative, too remote, or too tenuous.

Therefore, this action is dismissed on the independent grounds of lack of subject matter jurisdiction and lack of standing as to plaintiff MPF, but not as to plaintiffs GMC and Red Cross.

THE STATES' AUTHORITY TO TAX

Defendants contend that the Tax Injunction Act, 28 U.S.C. § 1341, precludes plaintiffs' request for this court to enjoin the assessment and/or collection of a tax. That provision does hold that the district court shall not interfere with the assessment, levy, or collection of any tax under state law where a plain, speedy, and efficient remedy may be had in state court.

The McCarran-Ferguson Act, 15 U.S.C. § 1011, *et seq.*, provides that the regulation and taxation of the business of insurance shall be subject to state law, and any state law effecting this purpose shall not be impaired unless a federal act specifically relates to the business of insurance.

Defendants in this action are plan fiduciaries, and the tax has not been levied directly upon them. Therefore, a state court remedy may not be available to them; but, ERISA does allow these defendants to bring an action in federal court. ERISA broadly preempts "any and all" state laws which relate to any employee benefit plan. 29 U.S.C. § 1144(a). Furthermore, in *Hewlett-Packard Co. v. Barnes,* 571 F.2d 502, 505 (9th Cir.) *cert. denied,* 439 U.S. 831, 99 S.Ct. 108, 58 L.Ed.2d 125 (1978) the Ninth Circuit determined that where the McCarran-Ferguson Act applies ERISA falls within the clause excepting federal laws that "specifically relate" to the business of insurance. The court recognized the policy of reserving to the states the power to regulate insurance unless an Act such as ERISA specifically relates to it. It then determined that ERISA was such an excepting Act. Therefore, ERISA was removed from the scope of prohibition against construing any federal law so as to impair or invalidate state law regulating insurance.

ERISA's PREEMPTIVE EFFECT

Two cases which discussed the relationship of state tax provisions to ERISA's preemption mandate are not Ninth Circuit cases, but they relate important legislative history relevant to the instant action. *Northwest Airlines, Inc. v. Roemer,* 603 F.Supp. 7, Empl. Benefit Cas. 1307 (BNA) (D.C.Minn.1984) held that ERISA preempts states' authority to levy a state income tax on ERISA-covered pension plans since the statutory language and legislative history indicated a congressional intent to preempt state tax laws as they relate to employee benefit plans. *National Carriers' Conf. Comm. v. Heffernan,* 454 F.Supp. 914 (D.C.Conn.1978) stated that a tax imposed upon an employee welfare benefit plan was void and unenforceable insofar as it applied to such plans covered by ERISA.

The *Northwest Airlines* defendant argued for a narrow construction of section 1144(a) contending that state law

"relates to" an employee benefit plan only if it regulates the terms and conditions of the plan. The court noted that such a narrow reading was rejected by the Supreme Court in *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 101 S.Ct. 1895, 68 L.Ed.2d 402 (1981). There, the Court held that ERISA makes clear that even indirect state action bearing upon private pensions may encroach upon the area of exclusive federal concern. Similarly, in *Shaw v. Delta Airlines*, 463 U.S. 85, 103 S.Ct. 2890, 77 L.Ed.2d 490 (1983) the Supreme Court carefully reviewed the legislative history of ERISA and concluded that Congress intended the words "relate to" to be construed in a "broad sense." The *Shaw* Court then held that ERISA preempts any law that has a connection with or reference to any employee benefit plan unless it falls within one of the exceptions—state laws regulating insurance, banking, or securities, or state criminal laws.

In *National Carriers'* the fiduciaries of an employee benefit plan sought injunctive and declaratory relief from the assessment and collection of a Connecticut tax on the plan. The court reasoned that the phrase "any and all" plainly indicated an intention to reach every state statute that fits the description of "relating to" an employee benefit plan. 454 F.Supp. at 915.

As the *Northwest Airlines* court acknowledged, any contention that ERISA preemption should be narrowly construed is undermined by Congress' specific identification of state legislation areas which were to be excepted from ERISA's preemption provision. When ERISA was originally considered, Congress rejected a request by the Secretaries of Labor and Treasury to exempt state taxation from preemption. In 1983, when ERISA's preemption language was amended to exclude Hawaii's experimental health benefit statute from ERISA's preemption provision, Congress specifically endorsed the preemption of state tax laws. That amendment added section 1144(b)(5)(B)(i) which reads in part:

> Nothing in subparagraph (A) shall be construed to exempt from subsection (a) [§ 1144(a)]—any State tax law relating to employee benefit plans . . . .

In the Conference Report which discussed this particular amendment, it was stated that

> [t]he provision generally exempts the Hawaii Prepaid Health Care Act from preemption by ERISA. Under the provision, however, preemption is continued with respect to . . . any State tax law relating to employee benefit plans . . . .
> H.R.Rep. No. 97-984, 97th Cong., 2d Sess. 18 (1982), U.S.Code Cong. & Admin. News, pp. 4580, 4603.

In addition, the legislative history of "Tax and ERISA Provisions," as related in 1982 U.S.Code Congressional and Administrative News at pages 4595-96, gives some indication of Congress' intent. It states:

> Also, the provision [the amendment] does not affect the status, under the preemption provisions of ERISA, of any state tax law relating to employee benefit plans.

These excerpts convey the impression that section 1144(b)(5)(B)(i) was directed to all state tax laws and was not just in response to Hawaii's plan.

The gravamen of ERISA's preemption thrust derives from some determination as to how the challenged law relates to the ERISA plan. Defendants characterize the gross premium tax as an assessment against Metropolitan for doing business in California. Yet, in fact, it is the amount which is paid out by the plaintiffs below the trigger point which is being treated as a premium received by Metropolitan and is being taxed. Under ERISA this taxation practice is preempted because it "relates to" or bears some connection or reference to the plans by using the plans' payments as a means of measuring taxable premiums. The defendants are indirectly taxing benefit pay-

ments and they are impeding the discretion of plan sponsors to fund their plan guarantees through a combination of general assets and excess risk insurance.

This court recognizes the important state interests which are involved in this action, and balances that consideration in its ruling. The strong congressional intent, however, to preempt those actions which affect ERISA plans directs this court to find that ERISA prevents the taxation practice which has taken place here.

It is ordered, therefore, that defendants motion for judgment on the pleadings be denied as to plaintiffs GMC and Red Cross, but granted as to Plaintiff MPF because it lacks standing. It is further ordered that defendants and their agents refrain from taxing plaintiffs' and other insurance companies based on their interpretation of "gross premiums," which includes in the amount subject to tax benefit payments from employee benefit plans to their participants.

SO ORDERED.

APPENDIX D

UNITED STATES DISTRICT COURT FOR THE CENTRAL DISTRICT OF CALIFORNIA

GENERAL MOTORS CORPORATION, *et al.*,

Plaintiffs,

v.

CALIFORNIA STATE BOARD OF EQUALIZATION, *et al.*,

Defendants.

No. CV 83-6801-DWW (KX)

Fiduciaries of employee benefit plans brought action seeking declaratory, injunctive and remedial relief against taxation of employer payments under certain disability and health care plans, alleging taxes were preempted by ERISA. The District Court, David W. Williams, Senior District Judge, in an amended order, held that: (1) fiduciary whose insurer had not been assessed a tax deficiency lacked standing; (2) injunctive relief was not precluded by the Tax Injunction Act; and (3) tax was preempted by ERISA.

Judgment accordingly.

See also 600 F.Supp. 76.

AMENDED ORDER DENYING DEFENDANT'S MOTION FOR JUDGMENT ON THE PLEADINGS AND GRANTING PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

DAVID W. WILLIAMS, Senior District Judge.

Plaintiffs, General Motors Corporation ("GMC") and the American National Red Cross ("Red Cross"), in their ca-

pacities as sponsoring employers and administrators of certain employee disability and health care plans established pursuant to collective bargaining agreements, and current trustees of the Motion Picture Health and Welfare Fund ("MPF"), are suing defendants, The California State Board of Equalization ("Board"), Board members, and certain state officials, for declaratory, injunctive, and remedial relief.

Both GMC and Red Cross entered into excess risk arrangements with the Metropolitan Life Insurance Company ("Metropolitan") providing that they would remain responsible for payments of all benefits from their respective plans below a trigger point. This trigger point was to be established annually based on a projected level of aggregate benefit payments. Local GMC units were to maintain claim records and evaluate and pay claims below the trigger amount for sickness and accident coverage. Metropolitan would perform these functions for other forms of coverage. The funds used to pay the pretrigger claims are drawn from GMC accounts. Similarly, the funds used to pay pretrigger claims for Red Cross are drawn by Metropolitan from a Red Cross account, and Metropolitan is authorized to draw on that account only to satisfy pretrigger claims.

Defendants levied taxes upon Metropolitan on benefits paid out of the GMC Disability Trusts, the GMC Plan, and the Red Cross Plan. As Metropolitan was indemnified by GMC and Red Cross for the tax payments, these costs were passed onto them.

The MPF entered into an excess risk arrangement with the Union Labor Life Insurance Company ("Union Labor") whereby MPF assumed the risk of paying benefits up to a defined trigger point. A year or so later the trustees of the fund resolved to terminate their excess risk policies and become completely self-insured with respect to those components covered by it. MPF now believes defendants

will levy a tax on benefits paid out during the year in which the excess risk arrangement was in existence. It too has an existing indemnity agreement, so the MPF assumes it will incur the cost for the tax.

Plaintiffs bring this action because defendants' interpretation of "gross premiums" was upheld by the California Supreme Court in *Metropolitan Life Ins. Co. v. State Board of Equalization,* 32 Cal.3d 649, 196 Cal.Rptr. 578, 652 P.2d (1982). In that action, for the years 1967–1969 Metropolitan was assessed an insurance franchise tax based upon the amount of Metropolitan's gross premiums. The Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq.,* was not at issue then, however, because the years involved were prior to ERISA's passage in 1974. Metropolitan has now raised that issue, and it has filed refund claims for the 1975–1982 years alleging that the franchise tax has been preempted by ERISA. These claims were denied, and Metropolitan has filed suit in San Francisco Superior Court.

The predominant legal issues raised in this action involve this court's jurisdiction, the plaintiffs' standing to sue, the State of California's power to tax in the manner at issue here, and ERISA's possible preemptive effect. The courts have favored a broad interpretation of ERISA's preemption provision. State taxation is not one of the enumerated exceptions to ERISA's preemptive reach. A recent ERISA amendment and relevant legislative history also indicate Congress' intent to preempt any state tax law which relates to employee benefit plans. Defendants' characterization of "gross premiums" in this context runs afoul of ERISA. Therefore, this court must rule that defendants' tax practice as described in this action is preempted by ERISA.

JURISDICTION AND STANDING

Jurisdiction is conferred upon this court through ERISA, 29 U.S.C. § 1132(a)(3) and (4). Plaintiffs are fiduciaries of

employee welfare benefit plans. As such, they have a direct and explicit statutory basis for standing. Section 1132(a)(3) provides that a fiduciary may bring a civil action to enjoin any act or practice which violates any provisions of a plan's terms. A participant or beneficiary may bring an action to recover benefits under the terms of his plan in state court, but plan fiduciaries must bring their preemption cases exclusively in federal court. Furthermore, defendants' interpretation of "gross premiums" and their assessment and collection orders based upon such an interpretation are "state action having effect of law." So, they are state laws within the meaning of ERISA's section 1144(c)(1).

Defendants contend that any injury suffered by plaintiffs results solely from plaintiffs' agreement with an insurance company to reimburse it for its tax payments. They cite *EMI Ltd. v. Bennett,* 738 F.2d 994 (9th Cir.1984) and *Shell Petroleum, N.V. v. Graves,* 709 F.2d 593 (9th Cir.1983) for the proposition that a third party who is not being taxed does not have standing to sue the taxing authority because his injury is neither direct, individual, distinct, nor palpable. *See also Allen v. Wright,* 468 U.S. 737, 104 S.Ct. 3315, 82 L.Ed.2d. 556 (1984). Plaintiffs' jurisdictional and standing foundation, however, arises under ERISA provisions as they bring this action as plan fiduciaries seeking to preempt a practice that relates to their employee benefit plans. ERISA expressly empowers fiduciaries to seek relief in federal court against "any act or practice" which violates ERISA's provisions. 29 U.S.C. § 1132(a)(3) and (f).

Although MPF is also a fiduciary under ERISA, no indication has been given that defendants' actions have had an adverse effect upon its employee benefit plan. Unlike GMC and Red Cross, there is no tax deficiency to speak of which has been asserted against Union Labor, MPF's insurer. MPF can assert ERISA in defense of actions affecting its plan, but it cannot be allowed to do so when the alleged effect is speculative, too remote, or too tenuous.

Therefore, this action is dismissed on the independent grounds of lack of subject matter jurisdiction and lack of standing as to plaintiff MPF, but not as to plaintiffs GMC and Red Cross.

THE STATES' AUTHORITY TO TAX

Defendants contend that the Tax Injunction Act, 28 U.S.C. § 1341, precludes plaintiffs' request for this court to enjoin the assessment and/or collection of a tax. That provision does hold that the district court shall not interfere with the assessment, levy, or collection of any tax under state law where a plain, speedy, and efficient remedy may be had in state court.

The McCarran-Ferguson Act, 15 U.S.C. § 1011, *et seq.*, provides that the regulation and taxation of the business of insurance shall be subject to state law, and any state law effecting this purpose shall not be impaired unless a federal act specifically relates to the business of insurance.

Defendants in this action are plan fiduciaries, and the tax has not been levied directly upon them. Therefore, a state court remedy may not be available to them; but, ERISA does allow these defendants to bring an action in federal court. ERISA broadly preempts "any and all" state laws which relate to any employee benefit plan. 29 U.S.C. § 1144(a). Furthermore, in *Hewlett-Packard Co. v. Barnes,* 571 F.2d 502, 505 (9th Cir.), *cert. denied,* 439 U.S. 831, 99 S.Ct. 108, 59 L.Ed.2d 125 (1978) the Ninth Circuit determined that where the McCarran-Ferguson Act applies ERISA falls within the clause excepting federal laws that "specifically relate" to the business of insurance. The court recognized the policy of reserving to the states the power to regulate insurance unless an Act such as ERISA specifically relates to it. It then determined that ERISA was such an excepting Act. Therefore, ERISA was removed from the scope of prohibition against construing any fed-

eral law so as to impair or invalidate state law regulating insurance.

ERISA's PREEMPTIVE EFFECT

Two cases which discussed the relationship of state tax provisions to ERISA's preemption mandate are not Ninth Circuit cases, but they relate important legislative history relevant to the instant action. *Northwest Airlines, Inc. v. Roemer,* Empl. Benefit Cas. 1307 (BNA) (D.C.Minn.1984) held that ERISA preempts states' authority to levy a stgate income tax on ERISA-covered pension plans since the statutory language and legislative history indicated a congressional intent to preempt state tax laws as they relate to employee benefit plans. *National Carriers' Conf. Comm v. Heffernan,* 454 F.Supp. 914 (D.C.Conn. 1978) stated that a tax imposed upon an employee welfare benefit plan was void and unenforceable insofar as it applied to such plans covered by ERISA.

The *Northwest Airlines* defendant argued for a narrow construction of section 1144(a) contending that state law "relates to" an employee benefit plan only if it regulates the terms and conditions of the plan. The court noted that such a narrow reading was rejected by the Supreme Court in *Alessi v. Raybestos-Manhattan, Inc.,* 451 U.S. 504, 101 S.Ct. 1895, 68 L.Ed.2d 402 (1981). There, the Court held that ERISA makes clear that even indirect state action bearing upon private pensions may encroach upon the area of exclusive federal concern. Similarly, in *Shaw v. Delta Airlines,* 463 U.S. 85, 103 S.Ct. 2890, 77 L.Ed.2d 490 (1983) the Supreme Court carefully reviewed the legislative history of ERISA and concluded that Congress intended the words "relate to" to be construed in a "broad sense." The *Shaw* Court then held that ERISA preempts any law that has a connection with or reference to an employee benefit plan unless it falls within one of the exceptions—state laws regulating insurance, banking, or securities, or state criminal laws.

In *National Carriers'* the fiduciaries of an employee benefit plan sought injunctive and declaratory relief from the assessment and collection of a Connecticut tax on the plan. The court reasoned that the phrase "any and all" plainly indicated an intention to reach every state statute that fits the description of "relating to" an employee benefit plan. 454 F.Supp. at 915.

As the *Northwest Airlines* court acknowledged, any contention that ERISA preemption should be narrowly construed is undermined by Congress' specific identification of state legislation areas which were to be excepted from ERISA's preemption provision. When ERISA was originally considered, Congress rejected a request by the Secretaries of Labor and Treasury to exempt state taxation from preemption. In 1983, when ERISA's preemption language was amended to exclude Hawaii's experimental health benefit statute from ERISA's preemption provision, Congress specifically endorsed the preemption of state tax laws. That amendment added section 1144(b)(5)(5)(i) which reads in part:

> Nothing in subparagraph (A) shall be construed to exempt from subsection (a) [§ 1144(a)]—any State tax law relating to employee benefit plans . . . .

In the Conference Report which discussed this particular amendment, it was stated that

> [t]he provision generally exempts the Hawaii Prepaid Health Care Act from preemption by ERISA. Under the provision, however, preemption is continued with respect to . . . any State tax law relating to employee benefit plans . . .
> H.R.Rep. No. 97-984, 97th Cong., 2d Sess. 18 (1982), U.S.Code Cong. & Admin. News 1982, pp. 4580, 4603.

In addition, the legislative history of "Tax and ERISA Provisions," as related in 1982 U.S. Code Congressional

and Administrative News at pages 4595–96, gives some indication of Congress' intent. It states:

> Also, the provision [the amendment] does not affect the status, under the preemption provisions of ERISA, of any state tax law relating to employee benefit plans.

These excerpts convey the impression that section 1144(b)(5)(B)(i) was directed to all state tax laws and was not just in response to Hawaii's plan.

The gravamen of ERISA's preemption thrust derives from some determination as to how the challenged law relates to the ERISA plan. Defendants characterize the gross premium tax as an assessment against Metropolitan for doing business in California. Yet, in fact, it is the amount which is paid out by the plaintiffs below the trigger point which is being treated as a premium received by Metropolitan and is being taxed. Under ERISA this taxation practice is preempted because it "relates to" or bears some connection or reference to the plans by using the plans' payments as a means of measuring taxable premiums. The defendants are indirectly taxing benefit payments and they are impeding the discretion of plan sponsors to fund their plan guarantees through a combination of general assets and excess risk insurance.

This court recognizes the important state interests which are involved in this action, and balances that consideration in its ruling. The strong congressional intent, however, to preempt those actions which affect ERISA plans directs this court to find that ERISA prevents the taxation practice which has taken place here.

It is ordered, therefore, that defendants' motion for judgment on the pleadings be denied as to plaintiffs GMC and Red Cross, but granted as to plaintiff MPF because it lacks standing. Plaintiffs' motion for summary judgment is granted. It is further ordered that defendants and their agents, employees, successors, and all persons in concert

with them cease and refrain from taxing indirectly the employee benefit plans of plaintiffs GMC and Red Cross based upon defendants' interpretation of "gross premiums," which includes, in the amount subject to tax, benefit payments from employee benefit plans to their participants.

AMENDED JUDGMENT

On the basis of all the evidence before me, I hereby declare, adjudge, and decree that:

1. Plaintiffs are fiduciaries of employee welfare benefit plans covered by the Employee Retirement Income Security Act of 1974 ("ERISA").

2. Defendants are officials of the State of California responsible in different capacities for imposing a franchise tax on insurance companies doing business in the State.

3. The California Constitution provides for taxation of insurance companies based on the "gross premiums received" by the insurance companies. Cal. Const., Art. XIII, § 28.

4. Defendants include in the "gross-premiums" amount subject to tax benefit payments from employee benefit plans to their participants based on the fiction that these amounts are "received", by insurance companies offering excess-risk insurance contracts to plan sponsors of employee benefit plans.

5. This characterization of benefit payments as "premium" payments was endorsed by the California Supreme Court in *Metropolitan Life Insurance Company v. State Board of Equalization,* 32 Cal.3d, 649, 186 Cal.Rptr 578, 652 P.2d 426 (1982).

6. ERISA preempts all "State laws," including state tax laws, "insofar as they . . . relate to" employee benefit plans. In *Shaw v. Delta Airlines,* 463 U.S. 85, 103 S.Ct.

2890, 77 L.Ed.2d 490 (1983), the Supreme Court made clear that the "relate to" language must be construed broadly to preempt all "State laws" that have "some reference to or connection with" employee benefit plans. *Id.*, 103 S.Ct. at 2899-2900.

7. The taxing practice at issue in the *Metropolitan Life* case is a "State law" which "relates to" employee benefit plans because it measures the "gross premiums" subject to tax by reference to employee benefit plan payments to participants and beneficiaries. This reference to plans is preempted by ERISA, since it results in indirectly taxing benefit plans and impeding the discretion of plan sponsors to purchase excess-risk policies.

Accordingly, it is hereby ordered that defendants and their agents, employees, successors, and all persons in concert with them cease and refrain from taxing indirectly the employee benefit plans of plaintiffs General Motors Corporation and the American Red Cross based upon defendants' interpretation of "gross premiums," which includes, in the amount subject to tax, benefit payments from employee benefit plans to their participants.

The court adopts as its finding of fact and conclusions of law the order issued for this action dated February 4, 1985.

APPENDIX E

FOR PUBLICATION

UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

GENERAL MOTORS CORPORATION; AMERICAN NATIONAL RED CROSS; JASPER BALLANCE; et al.,
Plaintiffs-Appellees,

v.

CALIFORNIA STATE BOARD OF EQUALIZATION; WILLIAM M. BENNET; CONWAY H. COLLIS; ERNEST J. DRONENBURG, JR.; RICHARD NEVINS; GRAY DAVIS*; and BRUCE BUNNER,
Defendants-Appellants.

No. 85-5618
D.C. No. CV-83-6801-DWW
ORDER

Filed August 14, 1987

Before: Anthony M. Kennedy, Otto R. Skopil, Jr. and Arthur L. Alarcon, Circuit Judges.

Appeal from the United States District Court for the Central District of California .

COUNSEL

William J. Kilberg, Washington, D.C., for the plaintiffs-appellees.

Patti S. Kitching, Los Angeles, California, for the defendants-appellants.

*Substituted for Kenneth Cory, pursuant to Fed. R. App. P. 43(c)(1).

Benjamin W. Boley, James R. Bieke, William R. Hanlon, Washington, D.C., for the amicus curiae.

ORDER

The decision of the Supreme Court in *Pilot Life Ins. Co. v. Dedeaux*, 107 S. Ct. 1549 (1987), does not alter the opinion's analysis. *Pilot Life* involves a state law of general application, one that directly conflicts with a substantive provision of ERISA. This case, in contrast, involves a state law directed specifically at the insurance industry, one that does not conflict with any of ERISA's substantive provisions. Accordingly, the analysis of *Metropolitan Life Ins. Co. v. Massachusetts*, 105 S. Ct. 2380 (1985), remains fully applicable.

The full court has been advised of the suggestion for en banc hearing, and no judge of the court has requested a vote on the suggestion for rehearing en banc. Fed. R. App. P. 35(b).

The petition for rehearing is denied, and the suggestion for a rehearing en banc is rejected.

APPENDIX F

SUPREME COURT OF CALIFORNIA

METROPOLITAN LIFE INSURANCE COMPANY,
Plaintiff and Respondent,

v.

STATE BOARD OF EQUALIZATION,
Defendant and Appellant.

S.F. No. 24306

Filed Oct. 28, 1982

Summary

After the State Board of Equalization rejected an insurer's claim for a tax refund, the insurer sued for a refund and obtained a judgment for the full amount requested. The insurer provided coverage for employee group medical benefit plans. Prior to 1967, employers financed the entire cost of such coverage through monthly premiums paid to the insurer, which paid a gross premiums tax on the total amount received pursuant to Cal. Const., art. XIII, § $14^4/_5$ (now § 28), and Rev. & Tax. Code, §§ 12201, 12221. Starting in 1967, the insurer offered a group medical insurance plan under which the employers were required to assume the obligation to pay all employee claims for benefits up to a "trigger-point" amount, defined as the actuarially predicted monthly average level of aggregate employee claims, and the insurer remained obligated to pay all claims in excess of that amount. Under this plan, the insurer retained control over many aspects of the administration of the plan. The insurer determined the amount of all benefits to be paid in satisfaction of em-

ployee claims, both above and below the trigger point, with the obligation to defend and the right to settle suits contesting rejection of claims. As to 13 of the 15 employers covered by the plan, the insurer actually paid claims from special accounts of the employers pursuant to authorization by the employers. Although the employers were primarily liable for payment of pretrigger-point claims, the obligations of the insurer were inextricably intertwined with those of the employers. If an employer failed to make funds available for the payment of the pretrigger-point claims in any month, the insurer remained obligated to cover the unpaid claims, subject to reimbursement from the delinquent employer. The California Insurance Commissioner levied a tax on the sum of the amounts employers paid to the insurer as premiums plus the aggregate yearly claims paid to employees by employers. The insurer paid the amount levied and sought a refund. (Superior Court of the City and County of San Francisco, No. 677543, Robert J. Drewes, Judge.)

The Supreme Court reversed. The court held that the employers acted as mere agents of the insurer for the collection of premiums and that the entire cost of the plan, including not only the amount paid directly to the insurer as a premium for coverage in excess of the trigger-point amount, but also the amount paid out of the employers' funds to satisfy employee claims, was taxable to the insurer as gross premiums under Cal. Const., art. XIII, § $14^4/_5$ (now § 28), and Rev. & Tax. Code, §§ 12201, 12221. (Opinion by Mosk, J., with Bird, C. J., Broussard, J., and Miller, J.,* concurring. Separate dissenting opinion by Kaus, J., with Reynoso, J., and Barry-Deal, J.,* concurring.)

Headnotes

Classified to California Digest of Official Reports, 3d Series

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* Assigned by the Chairperson of the Judicial Council.

(1) Insurance Contracts and Coverage § 1—Insurance—Definition.—The Legislature has defined insurance as "a contract whereby one undertakes to indemnify another against loss, damage, or liability arising from a contingent or unknown event." (Ins. Code, § 22.) Thus, insurance necessarily involves two elements: A risk of loss to which one party is subject and a shifting of that risk to another party; and distribution of risk among similarly situated persons.

(2a, 2b) Insurance Companies § 1—Taxation—Gross Premiums Tax—Amounts Includible in "Gross Premiums."—Under a group medical insurance plan which required employers to assume the obligation to pay all employee claims for benefits up to a "trigger-point" amount, defined as the actuarially predicted, monthly average level of aggregate employee claims, and required the insurer to pay all claims in excess of that amount, the entire cost of the plan, including not only the amount paid directly to the insurer as a premium for the coverage in excess of the trigger-point amount, but also the amount paid out of the employers' funds to satisfy employee claims, was taxable to the insurer as gross premiums under Cal. Const., art. XIII, § $14^4/_5$ (now § 28), and Rev. & Tax. Code, §§ 12201, 12221. Under the plan, the employers did not function as independent insurers; as a matter of law, they functioned only as agents of the insurer for collection of premiums. Accordingly, the "trigger-point" amount was analogous to the "net premium" under a standard group policy, and the amount paid directly to the insurer for costs of administration and to compensate the insurer for assuming the risk that claims experience might fluctuate above the expected level (or trigger-point) was analogous to the loading under a standard arrangement. Thus, the gross premium which was subjected to the gross premiums tax was composed of the sum of the actual pretrigger-point claims pay-

ments and the amount paid directly to the insurer as premiums.

[See **Cal.Jur.3d,** Franchise and in Lieu Taxes, § 24, **Am.Jur.2d,** State and Local Taxation, § 428 et seq.]

(3) **Insurance Companies § 1—Taxation—Gross Premiums Tax—Amounts Includible in "Gross Premiums."**—In determining what amounts are to be included within the meaning of the term "gross premiums" for purposes of the gross premiums tax imposed on insurers (Cal. Const., art. XIII, § $14^{4}/_{5}$ (now § 28); Rev. & Tax. Code, §§ 12201, 12221), the insurer is to be assessed a tax based on the total cost of the insurance coverage provided to the insured.

(4) **Insurance Contracts and Coverage § 20—Premiums Tax—Amounts Includible in "Gross Premiums."**—In determining what amounts are to be included within the meaning of the term "gross premiums" for purposes of the gross premiums tax imposed on insurers (Cal. Const., art. XIII, § $14^{4}/_{5}$ (now § 28); Rev. & Tax. Code, §§ 12201, 12221), the insurer is to be assessed a tax based on the total cost of the insurance coverage provided to the insured.

(4) **Insurance Contracts and Coverage § 20—Premiums—Gross Premium, Net Premium, Loading—Definitions.**—The gross premium, or the amount charged in a contract of insurance, ordinarily includes two elements, that is, the net premium and the loading. The loading, or the amount arbitrarily added to the net premium is intended to cover the expenses of the company. The net premium under standard group policies is the expected level of claims payment. The loading ordinarily is composed of miscellaneous charges, including administrative costs of the insurer, a charge for assuming the risk that claims outlays will exceed the expected level, and an element of profit or dividends.

(5) **Insurance Companies § 1—Taxation—Gross Premiums Taxes.**—The tax liability of an insurer should not depend on the bare formality of whether the employer pays the cost of benefits out of his own pocket or negotiates a pay raise with his employees, then deducts the costs of the plan from their salaries and forwards those amounts to the insurer. In both situations, the insurer obtains the same benefit of doing insurance business in this state. Accordingly, the entire cost of an employee benefit plan, whether paid from the employer's funds or financed by deductions from the salaries of employees, is taxable as gross premiums inuring to the benefit of the insurer.

Counsel

George Deukmejian, Attorney General, and Timothy G. Laddish, Deputy Attorney General, for Defendant and Appellant.

Hart H. Spiegel, Robert S. Daggett, Donald J. Heng, Jr., Brobeck, Phleger & Harrison and Gerard J. Talbot for Plaintiff and Respondent.

Opinion

MOSK, J.—The California Constitution imposes a franchise tax "on each insurer doing business in this state," measured by the amount of "gross premiums" which the insurer receives in a particular year. (Cal. Const., art. XIII, § 28 (formerly § 14⁴/₅); see also Rev. & Tax. Code, §§ 12201, 12221.) We must decide whether certain amounts, though never formally paid to Metropolitan Life Insurance Company (Metropolitan), nevertheless are to be included within the gross premiums measure of the tax imposed on its business done in California.

Metropolitan writes coverage for employee group medical benefit plans. Prior to 1967, employers financed the entire cost of such coverage through monthly premiums

paid to Metropolitan, which paid a premiums tax on the total amount received. With respect to the benefit plans for 15 large employers, however, Metropolitan has devised a new arrangement in which it claims to have shifted 90 percent of the obligation for medical benefit coverage to the employers and thereby reduced by 90 percent the gross premiums received from those employers, reducing its premiums tax liability accordingly. Because we conclude that under the new arrangement the employer is a mere agent of Metropolitan for collection of premiums, not an independent insurer, we attribute the entire cost of the group plan to Metropolitan's gross premiums and reverse the trial court's judgment granting a tax refund to Metropolitan.

Before 1967, when it began offering the "Mini-Met" plan which is the subject of the instant controversy, Metropolitan offered employers a plan denominated the standard group policy. According to the terms of such policies, the employers paid a premium in return for Metropolitan's assumption of the entire obligation to provide health coverage to benefitted employees. The premiums for the standard policies represented the entire cost of the agreed-upon coverage, and Metropolitan paid a tax calculated as a percentage of the total premiums it received.

The arrangements here at issue represent an alteration of Metropolitan's standard group policies. Under the standard plans, Metropolitan retained the benefit of the "float"—the use of premium funds from the time of payment until the funds were disbursed to satisfy claims. In addition, Metropolitan apparently passed through to the employers, as an element of premiums, the amount of its premiums tax liability. Motivated by the desire to reduce the cost of insurance coverage and to obtain an improved cash-flow situation, the employers persuaded Metropolitan to modify its group insurance coverage. Metropolitan obliged by developing the Mimi-Met rider to the standard group policy. The rider shifted certain cash-flow advantages to the em-

ployers and sought to substantially reduce Metropolitan's premiums tax liability.

The Mini-Met rider required employers to assume the obligation to pay all employee claims for benefits up to a "trigger-point" amount, defined as the actuarially predicted, monthly average level of the aggregate employee claims. Metropolitan remained obligated to pay all claims in excess of that amount. Because Metropolitan was primarily obligated to pay employee claims only after the trigger point was reached for a particular month, it charged the employers a premium reduced by 90 percent. Hence, rather than paying a single premium to Metropolitan as they had previously done, the employers who elected to adopt the Mini-Met rider paid pretrigger-point claims directly to the employees and paid the smaller premium to Metropolitan.

The employers obtained cash-flow benefits from the modified arrangement, since they had the use of their funds until claims were actually paid out. They obtained an additional, limited benefit if the total claims for any month did not reach the trigger-point amount. This situation was referred to as "favorable claims experience." Any amounts by which the aggregate level of claims was less than the trigger-point amount were carried forward to the next month, increasing the trigger-point amount for that month. However, there was no carryover from year to year. Further, the employers and Metropolitan anticipated a substantial reduction in premiums tax liability, expecting to calculate the tax solely on the basis of the reduced direct monthly payments to Metropolitan.

For the three tax years in question (1967-1969), Metropolitan urged that it was entitled to a 90 percent reduction in its tax liability as a consequence of the Mini-Met rider. The California Insurance Commissioner, unpersuaded by Metropolitan's position, levied a tax based upon the sum of the amounts employers paid to Metropolitan

as premiums plus the aggregate yearly claims paid to employees from employers' funds. On October 29, 1973, Metropolitan paid $969,363.80 in tax assessments and interest.[1] After the State Board of Equalization (Board) rejected its claim, Metropolitan sued for a refund and obtained a judgment for the full amount requested. The Board appeals from the ruling.

(1) The Legislature has defined insurance as "a contract whereby one undertakes to indemnify another against loss, damage, or liability arising from a contingent or unknown event." (Ins. Code, § 22.) Thus, insurance necessarily involves two elements: (1) a risk of loss to which one party is subject and a shifting of that risk to another party; and (2) distribution of risk among similarly situated persons. (See *California Physicians' Service* v. *Garrison* (1946) 28 Cal.2d 790, 803-804 [172 P.2d 4, 167 A.L.R. 306]; 12 Appleman, Insurance Law and Practice (1981) § 7001, p. 4).

That the employees are the insureds under employer-provided group health insurance plans cannot seriously be disputed. We plainly stated in *Elfstrom* v. *New York Life Ins. Co.* (1967) 67 Cal.2d 503, 514, footnote 9 [63 Cal.Rptr. 35, 432, P.2d 731], that "the employee, in the tri-partite group insurance situation is the real insured under the policy." More generally, Insurance Code section 23 provides that "the person indemnified is the insured." Employee health plans cover the risk of injury or disability of the employees; the employees receive indemnification where such loses occur. That the employer may be the nominal policyholder is not significant; the employees remain those against whose potential loss the insurer provides indemnification.

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[1] The parties hve stipulated that Metropolitan is entitled to a judgment of refund in the amount of $12,690 plus $3,362.85 paid as interest, plus interest on both amounts as provided in Revenue and Taxation Code section 13107. The amount overpaid was the result of a typographical error in the tax assessment for 1968.

Although willing to assume arguendo that the employees are the true insureds under the type of arrangement here at issue, Metropolitan nevertheless maintains that the employees are insureds of Metropolitan only to the limited extent of its "excessive risk" coverage. Metropolitan would have us characterize the Mini-Met plan as purely an excessive risk policy; Metropolitan asserts that the employers are separate insurers as to all employee claims aggregating less than the trigger-point amount. Thus, reasons Metropolitan, the cost of the employer-provided portion of the medical benefit coverage is not taxable as gross premiums because the employer is not an "insurer doing business in this state" within the meaning of the taxing provisions here at issue.[2] The Board counters with the argument that Metropolitan was the sole insurer under the Mini-Met plan, bearing the entire insurance risk.

The Board relies heavily on *California Physicians' Service* v. *Garrison* (1946) *supra*, 28 Cal.2d 790, to support its position. The California Physicians' Service (CPS) was a nonprofit corporation formed to provide affordable health care coverage to low income persons. CPS collected monthly dues from the insureds, who were termed "beneficiary members" of the corporation; it distributed the dues to physicians—termed "professional members"—in payment for medical services rendered to the beneficiary members. The physicians had agreed to seek compensation solely from the fund created by dues collection. Thus, when the amount of dues collected in a particular month was

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[2] Metropolitan cites *Cal-Western Ins. Co.* v. *St. Bd. of Equal.* (1957) 151 Cal.App.2d 559 [319 P.2d 19]. In that case, an employer had established an employee retirement plan, without insurance coverage. The employees contributed toward the plan through payroll deductions. Relying on the absence of a profit motive, the court held that the employer was not engaged in an insurance business and therefore was not subject to the gross premiums tax on the amount of employee contributions. (Accord, *Mutual Life Ins. Co. of N.Y.* v. *New York St. Tax Comm'n* (1973) 345 N.Y.S.2d 475 [32 N.Y.2d 348, 298 N.E.2d 632].)

insufficient to fully compensate all the physicians for their services, CPS would disburse to each physician a pro rata payment calculated according to the value of services rendered.

The main issue in *Garrison* was whether CPS was conducting an insurance business and therefore subject to statutes regulating insurers. Those statutes required, among other matters, maintenance of adequate financial reserves to guarantee that insurers would be able to fulfill their coverage obligations. We declined to subject CPS to the regulations applicable to insurance businesses, reasoning as follows: "The business of the Service lacks one essential element necessary to bring it within the scope of the insurance laws, for clearly it assumes no risk. Under the provisions of the contracts or group agreements, it is a mere agent or distributor of funds. . . . The professional member is compensated for his services solely from the fund created by the monthly dues of the beneficiary members. . . . Stated in terms of insurance, all risk is assumed by the physicians, not by the corporation. . . ." (*Id.*, at pp. 804-805).

We explained and modified the *Garrison* holding in *People* ex rel. *Roddis* v. *Cal. Mut. Assn.* (1968) 68 Cal.2d 677 [68 Cal.Rptr. 585, 41 P.2d 97]. (See also *Maloney* v. *American I. M. & H. Assn.* (1953) 119 Cal.App.2d 319, 325 [259 P.2d 503].) California Mutual Association (CMA) was a nonprofit association organized to reimburse physicians and hospitals who rendered services to CMA's members. CMA financed its operation by collecting periodic dues from its members. Some of the physicians had agreed to look exclusively to CMA for payment of the scheduled fees. Other physicians provided services to CMA members without agreeing to seek reimbursement from any particular fund. As to this latter group of doctors, the patient-members were personally liable for payment of their medical expenses if CMA failed to meet its obligations. The issue in *Roddis*, as in *Harrison*, was whether CMA was an "in-

surer" and hence subject to statutory financial responsibility requirements or a mere "health care service plan" exempt from the statutory requirements. Noting that the purpose of the statutes was to protect insureds and the public, we reasoned that a health care provider should be required to maintain financial reserves only when there was some possibility that the provider, should it default, would leave the insureds subject to personal liability to physicians who had rendered services to them. We stated: "Where indemnity features are present, the member bears the risk of personal liability for medical services. This is the insurance risk which can be protected against by financial reserves to assure that the member will receive the benefits for which he has paid. . . . We, therefore, conclude that where indemnity is a significant financial proportion of the business, the organization must be classified as an 'insurer' for the purposes of the Knox-Mills Plan Act. . . . Although CMA's contracts with [the first group of] physicians provide for direct service without indemnity, the remainder of the plan is one of insurance." (*Id.*, at pp. 682-683.)

In their briefs, the parties have exhaustively discussed *Garrison* and *Roddis*. A careful review of those two cases, however, leads us to conclude that although they are generally helpful to an understanding of the nature of insurance and the need for financial stability of insurers, they bear only tangentially on the issues in the present case. The purpose of the taxing provisions which we interpret here is not to protect insureds, but rather to exact payments from insurers doing business in California; the gross premiums measure is apparently designed to approximate the volume of business done in this state, and thus the extent to which insurers have availed themselves of the privilege of doing business in California. (See generally *Ind. Indem. Exch.* v. *State Bd. Equalization* (1945) 26 Cal.2d 772, 775-776 [162 P.2d 222].)

The presence or absence of insurance risk on the part of the employers is not alone determinative of Metropolitan's tax liability. A more illuminating inquiry is whether the purpose of the taxing provisions can best be fulfilled by including amounts paid on pretrigger-point claims within the gross premiums measure of Metropolitan's tax. To myopically focus on the employers' status diverts attention from this central issue. In attempting to fulfill the purpose of the gross premiums tax, it is preferable to look beyond the formal labels the parties have affixed to their transactions and seek, rather, to discern the true economic substance of the Mini-Met arrangement. We thus consider the insurance arrangement as a whole.

Insofar as *Garrison* and *Roddis* aid in the resolution of the issue here presented, they support the Board's argument that the employers under the Mini-Met arrangement functioned not as independent insurers but at "mere agent[s] or distributor[s] of funds." (*Garrison, supra*, 28 Cal.2d at p. 804.) Under the Mini-Met arrangement, Metropolitan retained control over many aspects of the administration of the total plan. Metropolitan determined the amount of all benefits to be paid in satisfaction of employee claims, both above and below the trigger-point, with the obligation to defend and the right to settle suits contesting rejection of claims. As to 13 of the 15 employers covered by the Mini-Met package, Metropolitan actually paid claims from the special accounts of the employers pursuant to authorization by the employers. Rather than paying the cost of group insurance directly to Metropolitan, these employers deposited the money into accounts under Metropolitan's control. The payments to employees from such accounts constituted an element of overall cost of the insurance package in the same manner as if those amounts had been paid to Metropolitan as "premiums" then forwarded to the employees by Metropolitan in satisfaction of the employee claims. For the purpose of calculating the gross premiums tax, we can discover no

reasoned basis for distinguishing between the situation here presented and the former arrangement between Metropolitan and the employers. Metropolitan continued to derive substantially the same benefit of doing business in California and should logically have continued to incur the same tax liability.

True, the employers were primarily liable for payment of pretrigger-point claims. However, the obligations of Metropolitan were inextricably intertwined with those of the employers. If an employer failed to make funds available for payment of pretrigger-point claims in any month, Metropolitan remained obligated to cover the unpaid claims, subject to reimbursement from the delinquent employer.[3] The Mini-Met arrangement would then automatically terminate and the standard Metropolitan coverage would revert into effect at the end of the month in question. The employer would then be liable to Metropolitan for a termination premium, equal to the total premiums which would have been payable to Metropolitan from the employer in the current policy year had the standard group policies remained in effect, less the sum of the Mini-Met premiums paid to Metropolitan in that year plus the claims actually paid to employees from employer funds in that year.

Furthermore, the employers had a fixed limit on the amount of funds they were obligated to make available in each month, a limit corresponding to the expected level

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[3] We have not ignored Metropolitan's explanation that the provision in question was inserted "for administrative convenience to be certain that if there were a breakdown in communication or an inadvertent hiatus [in payments] on the part of the employer, the employees woyuld get their checks without interruption." Metropolitan also points out that no employer has yet failed to pay a pretrigger-point claim. Neither of these facts, assuming them to be true, diminishes the effect of the clear legal liability of Metropolitan to make pretrigger-point payments if an employer should defualt for any reason, as, e.g., in the event of insolvency.

of claims. Metropolitan thus bore the substantial insurance risk under the Mini-Met arrangement—the risk that the actual level of claims for a given month might exceed the predicted level. Given this highly entangled, symbiotic relationship between the employers and Metropolitan, it is hard to accept Metropolitan's contention that in providing funds for payment of pretrigger-point claims, the employers were discharging their independent liabilities as separate insurers.[4]

The Board persuasively argues that the employers role vis-a-vis the employees was that of an agent for the insurer. Metropolitan rebuts by citing the trial court's "finding of fact" that "[i]n making the medical benefit payments for which it was obligated, the employer was acting as principal, for its own account, and not as agent for Metropolitan Life Insurance Company." Metropolitan cites a number of general authorities for the proposition that whether an agency relationship exists is normally a question of fact. (See *Seneris* v. *Haas* (1955) 45 Cal.2d 811, 831 [291 P.2d 915, 53 A.L.R.2d 124]; *Brokaw* v. *Black-Foxe Military Institute* (1951) 37 Cal.2d 274, 278 [231 P.2d 816].) It also cites cases holding that an employer is an agent of its employees when negotiating the terms of a group policy with the insurer. (See *Madden* v. *Kaiser Foundation Hospitals* (1976) 17 Cal.3d 699, 705 [131 Cal.Rptr. 882, 552 P.2d 1178]; *Blos* v. *Bankers Life Co.* (1955) 133 Cal.App.2d 147, 150-151 [283 P.2d 744].) These cases are not apposite because a factual question becomes a question of law when the facts can be viewed in only one way. *Elfstrom* v. *New York Life Ins. Co.* (1967), *supra*, 67 Cal.2d 503, is controlling on the question of agency.

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[4] Metropolitan's contention that the employers are separate insurers bearing the bulk of the insurance risk under the Mini-Met plan is rendered less persuasive by its earlier admission in its claims for refund that "there was no risk in connection with the normal claims for activity for which the deductible amount [the trigger-point amount] was calculated."

In *Elfstrom*, we overturned the trial court's factual finding that the employer's bookkeeper was not an agent of the insurer; the bookkeeper had included an ineligible employee within group insurance coverage. Even though the insurance company itself did not know or have reason to know of the employee's ineligibility, the knowledge of its agents—the bookkeeper and the employer—was inputable to the insurer. We held *as a matter of law* that "the employer is the agent of the insurer in performing the duties of administering group insurance policies." (*Id.*, at. p. 512.) *Elfstrom* was recently reaffirmed in *Bass* v. *John Hancock Mut. Life Ins. Co.* (1974) 10 Cal.3d 792, 797-798 [12 Cal.Rptr. 195, 518 P.2d 1147]. (See also *Bareno* v. *Employers Life Ins. Co.* (1972) 7 Cal.3d 875, 883 [103 Cal.Rptr. 865, 500 P.2d 889]; *Amberg* v. *Bankers Life Co.* (1971) 3 Cal.3d 973, 979 [92 Cal.Rptr. 273, 479 P.2d 633].)

(2a) An examination of the facts of this case leads us to the conclusion that the employers in this case, as in *Elfstrom*, acted as mere agents of an insurer. The function of the employers under the Mini-Met arrangement was extremely limited; 13 out of 15 employers did no more than to establish and fund, on a continuing basis, bank accounts out of which Metropolitan, by special authorization, disbursed benefit payments for employee claims aggregating less than the trigger-point amount in a particular month. The remaining two employers paid out benefits without the assistance of Metropolitan. Surely these activities fall within the ambit of "administration" of a group insurance policy and constitute doing business in California. Thus, the employers are to be treated as agents of Metropolitan, as a matter of law.

Having determined that there was but one insurer under the Mini-Met package and that the employers functioned as agents of the insurer, we arrive at the issue whether the pretrigger-point claims payments, although financed by the employers, should be included within the total amount on which Metropolitan must pay a gross-premiums tax.

Several cases pertain to the more general question of what amounts are included within the meaning of the term "gross premiums." The initial authority is *Ind. Indem. Exch.* v. *State Bd. Equalization* (1945) *supra*, 26 Cal.2d 772, in which we held that a fee paid to attorneys at the expense of subscribers to an insurance exchange was included within the meaning of gross premiums because it was an element of the cost of the insurance.

Groves v. *City of Los Angeles* (1953) 40 Cal.2d 751 [256 P.2d 309], repeated the analysis of *Ind. Indem. Exch.* There, the agent of a bail bond insurer charged a percentage commission on the bonds he sold. A portion of the commission was forwarded to the principal, the agent retaining the remainder to cover expenses and as remuneration for his services. We held that the entire amount paid to the agent was includible within the gross premiums measure, not just the portion ultimately received by the bail bond company. Our reasoning went as follows: "[T]he basic theory is that the amount paid by the insured for the insurance is the premium. Here, as the bail agent is the insurer's agent, what he receives from the applicant for the insurance—that is, what the applicant pays for the bail bond is the premium. What the agent receives, in legal effect the insurer receives. The so-called 'fees' received by the bail agent do not result in a reduction of the cost to the insured." (*Id.*, at p. 761; accord, *Stuyvesant Insurance Co.* v. *State Tax Comm'n* (1972) 39 App.Div.2d 804 [332 N.Y.S.2d 314].

The holding and principles of *Groves* were applied in *Allstate Ins. Co.* v. *State Board of Equal.* (1959) 169 Cal.App.2d 165 [336 P.2d 961]. There, the insurer charged a fee if the insured elected to make his payments in installments. The fee covered the additional expenses of the insurer occasioned by the need to collect multiple payments. The court required inclusion of the "installment payment fee" within the gross premiums measure, reasoning that a " '[p]remium' in the law of insurance means

the amount paid to the company for insurance. [Citation.] It has been defined as 'the sum which insured is required to pay.' " (*Id.*, at p. 168.)

(3) From the above cases we derive the general rule that the insurer is to be assessed a tax based on the total cost of the insurance coverage provided to the insured. Before applying this principle to the facts of the present case, we review some basic concepts relating to the calculation of insurance premiums. **(4)** "The gross premium, or the amount charged in a contract of insurance, ordinarily includes two elements, that is, the net premium and the loading. The loading, or the amount arbitrarily added to the net premium, is intended to cover the expenses of the company." (*Allstate Ins. Co.* v. *State Board of Equal.* (1959) *supra*, 169 Cal.App.2d at p. 168). The net premium under standard group policies is the expected level of claims payments. The loading ordinarily is composed of miscellaneous charges, including administrative costs of the insurer, a charge for assuming the risk that claims outlays will exceed the expected level, and an element of profit or dividends. **(2b)** Under the Mini-Met arrangement, the trigger-point amount is analogous to the net premium under a standard arrangement. As Metropolitan's expert testified, the second element of the cost of the Mini-Met plan, totalling 10 percent of its cost, is computed essentially by adding the costs of administration to the premium to compensate Metropolitan for assuming the risk that claims experience may fluctuate above the expected level or trigger-point. Thus, the amount the employers paid directly to Metropolitan under the Mini-Met plan—the only amount on which Metropolitan intended to pay a premiums tax—is analogous to the loading under a standard arrangement. To compute the total cost of the Mini-Met insurance package, we must add together the two elements of the premium, the net premium and the loading. Thus, the gross premium is composed of the sum of the actual pretrigger-

point claims payments and the amount paid directly to Metropolitan as premiums.

Metropolitan argues that part of the cost of the Mini-Met plan is paid by the employers, not by the employees. This argument is said to support Metropolitan's ultimate contention that only those amounts paid to Metropolitan by the employers should be taxed as gross premiums. However, we view the situation differently. As will appear, we conclude that the employees, as a practical matter, bear the full expense of insurance coverage. In financing payment of pretrigger-point claims, the employers act as mere agents of Metropolitan, accumulating funds to be disbursed in a manner inuring to the economic benefit of Metropolitan.

Only in a formalistic sense can it be said that the employers bear the cost of the benefit plans which they provide to their employees. Group insurance coverage is an element of the employees' compensation and fringe benefit package negotiated through the collective bargaining process. The labor of the employees is the true source of the benefits, which are a form of additional compensation to them.[5] We fully concur in the following passage from *Insurance Co. of North America* v. *Bechtel* (1973) 36 Cal.App.3d 310 [111 Cal.Rptr. 507]: "Since the employer's contribution to the premium on group insurance is a fringe benefit, whether it be the full amount of the premium or

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[5] *Teamsters* v. *Daniel* (1979) 439 U.S. 551 [58 L.Ed.2d 808, 99 S.Ct. 790], cited by Metropolitan, does not compel a contrary result. There the court was considering whether employer contributions to a pension plan on an employee's behalf should be treated as an investment by the employee in a security. The court stated "Only in the most abstract sense may it be said that an employee 'exchanges' some portion of his labor in return for these possible benefits." (*Id.*, at p. 560 [58 L.Ed.2d at p. 817].) Viewed in context, the above-quoted statement does not contradict or even relate to our holding that employees are to be treated as the persons who finance employer-provided benefit plans for purposes of our state premiums tax.

only part of it, the extent of premium paid by the employer is not controlling. There is no practical difference between a pay raise to an employee out of which he pays part of the premium on his group insurance and direct payment of the premium by the employer." (*Id.*, at p. 317.) Although the court was addressing a different issue, the logic of its reasoning applies equally to the facts of the present case. **(5)** The tax liability of an insurer should not depend on the bare formality of whether the employer pays the cost of benefits out his own pocket or negotiates a pay raise with his employees, then deducts the cost of the plan from their salaries and forwards those amounts to the insurer. In both situations, the insurer obtains the same benefit of doing insurance business in this state. Accordingly, we hold that the entire cost of an employee benefit plan, whether paid from the employer's funds or financed by deductions from the salaries of employees, is taxable as gross premiums inuring to the benefit of the insurer.

Applying this rule to the facts of the instant case, we hold that Metropolitan is taxable on the sum of the premium payments it received from the employers and the pretrigger-point claims paid from employer funds in the tax years in question.

The judgment is reversed and the case remanded to the trial court with directions to enter judgment for Metropolitan only in the amount of the erroneous assessment described in footnote 1, *ante*.

Bird, C. J., Broussard, J., and Miller, J.,* concurred.

KAUS, J., Dissenting.—Article XIII, section 28 of the California Constitution imposes a tax on (1) gross *premium*, (2) *received* by (3) an *insurer*. The majority imposes this tax on (1) *losses* (2) *paid* to (3) *doctors and hospitals* and the like. What went wrong?

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* Assigned by the Chairperson of the Judicial Council.

I might join the majority if there were any evidence that the Mini-Met plan is just a bookkeeping trick by which Metropolitan intercepts 90 percent of the premiums at the source and, instead of running the money through its own books, causes it to be paid out directly to cover losses which Metropolitan would inevitably have incurred under the pre-Mini-Met arrangement. This kind of tax evasion could have been attempted by setting the trigger-point at an unrealistically low figure so that—barring a series of medical miracles—the actuarial possibility that the employers would actually save money by not having to disburse funds up to the trigger-point was nil. The fact—not mentioned in the majority opinion—is exactly the opposite: the record shows that in many months actual payments were well below the trigger-point *and that in 32 out of 42 policy years examined the total payments did not reach the trigger-point.*[1] Thus it cannot be contended that all the Mini-Met rider achieved was a fictitious reclassification of the first 90 percent of premium income as a deductible loss. Rather, the effect of the rider was just what is purported to be: it converted the pre-1967 full coverage policy into a genuine policy of excess insurance—quite similar to the deductible collision coverage must of us carry on our automobiles. If a motorist carries $100 deductible collision coverage and pays out $85 for a minor repair, no one can rationally claim that he is paying a premium, rather than a loss.[2]

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[1] The majority is therefore quite unjustified in saying that "[f]or the purpose of calculating the gross premiums tax, we can discover no reasoned basis for distinguishing between the situation here presented and the former arrangement between Metropolitan and the employers." (*Ante*, p. 657.) Is there no reasoned basis for distinguishing between payment for the actual cost of a small loss and payment of a premium for an actuarially anticipated greater loss?

[2] " 'Premium' in the law of insurance means the amount paid to the company for insurance." (*Allstate Ins. Co.* v. *State Board of Equal.* (1959) 169 Cal.App.2d 165, 168 [336 P.2d 961].) As a former Attorney

It is a safe guess that if Metropolitan and the employers had started to do business under the Mini-Met rider, the board would never have attempted the impossible: to convert excess insurance into full coverage. It is only because Metropolitan and the employers, for perfectly legitimate business reasons, changed plans in a way which resulted in considerable premium savings, that the board developed fancy theories to recoup its losses in tax revenue.[3] Yet all the evidence is to the effect, and the trial court expressly found, that "Mini-Met was not developed as a tax avoidance device. It was an excess insurance arrangement developed to effect, and did effect, substantial and bona fide changes in the financial, economic, contractual and legal relationships among Metropolitan, the employers and the employees from those existing under a full coverage insurance policy." The court further found that the impetus for the change from full coverage to Mini-Met came from the employers who "developed an increased awareness of the importance of 'cash-flow' management and investment of corporate funds.' " Some employers even considered 'shifting to non-insurance. It was only when faced with this loss of business that Metropolitan reluctantly started to offer the so-called "Met-Cat" plan, Mini-Met's predecessor. The trial court therefore concluded, after reiterating that Mini-Met was "not a tax avoidance scheme lacking in substance," that "it was 'compelled by business realities' and 'imbued with tax-independent considerations.' " While the business considerations which caused a

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General said of an insured's payment of the deductible portion of a loss: "Obviously this is not the price of any insurance and is in no sense a 'premium.' " (48 Ops.Cal.Atty.Gen. 49, 53 (1966).)

[3] The New York authorities were more generous. Prat of the record before us is a letter opinion from the New York Attorney General, dated December 27, 1966. In reply to a request of an opinion concerning the effect of Tax Law section 187 on what eventually became the Mini-Met rider, it said: "In my opinion, the amount of benefits paid out by employers to employees are in no sense a 'premium' received by the insurer and are therefore not taxable to the insurer under § 187."

genuine economic demand for a type of excess insurance such as Mini-Met are fairly set forth in the majority opinion, their significance becomes quickly lost in what I respectfully submit to be an irrelevant detour into the law of agency.

The basic fallacy of the majority opinion is revealed at its outset. It says that "[b]ecause we conclude that under the [Mini-Met] arrangement the employer *is a mere agent of Metropolitan for collection of premiums,* not an independent insurer,[4] we attribute the entire cost of the group plan to Metropolitan's gross premiums . . . ." (Italics added; *ante,* p. 652.) In support of its agency theory, the majority relies heavily on *Elfstrom* v. *New York Life Ins. Co.* (1967) 67 Cal.2d 503 [63 Cal.Rptr. 35, 432 P.2d 731], a case which in my view is not even remotely in point. That case held only that when an employer erroneously extends coverage to an employee who is not eligible for insurance, the insurer is bound by the employer's mistake because "the employer is the agent of the insurer in performing the duties of administering group insurance policies" vis-à-vis the insured employees. (*Id.,* at p. 512; accord, *Bass* v. *John Hancock Mut. Life Ins. Co.* (1974) 10 Cal.3d 792, 797-798 [112 Cal.Rptr. 195, 518 P.2d 1147]; *Bareno* v. *Employers Life Ins. Co.* (1972) 7 Cal.3d 875, 883 [103 Cal.Rptr. 865, 500 P.2d 889]; *Amberg* v. *Bankers Life Co.* (1971) 3 Cal.3d 973, 979 [92 Cal.Rptr. 273, 479 P.2d 633].) *Elfstrom* did not purport to hold that an employer is the agent of an insurer—as a matter of law—*for all purposes,* and it certainly did not decide that payments made by an employer to its employees' health providers from its own funds in

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[4] The majority seems to suggest that unless the employers are "insurers" for pretrigger-point losses, Metropolitan necessarily assumes that role. I disagree. The employers are simply fulfilling their contractual obligations toward their employees. If, in doing so, they run afoul of an unspecified part of the Insurance Code or some other law, that is another lawsuit. It certainly does not turn funds disbursed by them into premiums received by Metropolitan.

payment of its own contractual obligations should invariably be treated as gross premiums of an insurer which receives a different premium for covering a different risk. To say, as the majority does, that the employers in this case somehow "administered" Metropolitan's policy—a la *Elfstrom*—by paying pretrigger-point losses assumes the point to be proven: that these payments were not what they appeared to be, namely the employers' own losses, but payments to satisfy an obligation which Metropolitan had assumed by receiving a premium therefor, namely the payment made by the employers. The self-levitating nature of this argument is evident.

In contrast to the majority's conclusion, the trial court found that "in making the medical benefit payments for which it was obligated, the employer was acting as principal, for its own account, and not as agent of Metropolitan . . . ." The record not only justifies but compels that finding. As noted in the majority opinion two employers paid benefits below the trigger-point without any assistance by Metropolitan. Actually, out of a total of about $33 million of payments in issue, these two employers accounted for over $24 million—about 73 percent! How payments made by those two employers to satisfy their own obligations toward their own employees can be tortured into acts which "fall within the ambit of 'administration' of a group insurance policy" (*ante,* p. 659) is simply beyond me.

Legally the situation is no different as far as the other 13 companies are concerned. It will be recalled that they placed funds into accounts on which Metropolitan was permitted to draw in payment of claims below the trigger-point—payments for which the employers were responsible. Testimony at the trial described the arrangement as follows: "Generally a special bank account is set up where the employer wants the Metropolitan *to provide the claim service* on his liability, claim service being actually paying the claims . . . and he sets up a special bank account so that we can draw a draft on his account for the payment

of his benefit, for the payment of his liability." (Italics added.)[5] Naturally, where the insurance company has excess exposure for which it receives a premium, the cost of providing this claim service for losses below the excess is calculated into the premium, but the tax *on that premium* which Metropolitan concededly "received," is not at issue here. What the majority fails to explain is how Metropolitan's furnishing this type of claim service for funds which it has not, and never will, receive, justifies treating all of these funds of the employer as gross premiums received by Metropolitan. In any event, as to these 13 employers, it is obviously Metropolitan who is administering the employers' funds, and not—as the majority apparently claims—vice versa. I simply cannot understand how putting money into a bank account and watching it dwindle amounts to administering Metropolitan's policy.[6]

Having satisfied itself that the employers were agents of Metropolitan, the majority faces its biggest challenge—"the issue whether the pretrigger-point claims payments, although financed by the employers, should be included within the total amount on which Metropolitan must pay a gross-premiums tax." (*Ante,* p. 659.) It then analyzes several cases such as *Groves* v. *City of Los Angeles* (1953) 40 Cal.2d 751 [256 P.2d 309] to establish that the gross premium may include certain charges such as attorneys fees (*Ind. Indem. Exchange* v. *State Bd. of Equalization* (1945) 26 Cal.2d 772 [161 Cal.Rptr. 222]), commissions (*Groves, supra*), or an "installment payment fee." (*Allstate Ins. Co.* v. *State Board of Equal.* (1959) 169 Cal.App.2d

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[5] Testimony also revealed that employers who have no insurance at all can "rent" the claim service of an insurance company on an "ASO"—administrative services only—basis.

[6] The curious thing about the majority opinion is that it reaches its conclusion that "the employers are to be treated as agents of Metropolitan as a matter of law" just a few lines after correctly pointing out that the "function of the employers under the Mini-Met arrangement was extremely limited; . . ." (*Ante,* p. 659.)

165, 168 [336 P.2d 961].) Then, taking off from a statement in *Allstate* that premium rates are based on the expected losses ("pure premium") and expenses ("loading"), the majority jumps to the untenable conclusion that "[u]nder the Mini-Met arrangement, the trigger-point amount is analogous to the net premium under a standard arrangement." (*Ante,* p. 660.) In other words, the premium which the employers do *not* pay is really part of the net premium received by Metropolitan! Obviously this argument too simply assumes the result it strives to reach: that the employers are insured up to the trigger-point and that when they pay a pretrigger-point loss, they are really paying a premium.[7]

Even so, the majority is not out of the woods. After all the taxable event is the *receipt* of premiums by Metropolitan—as is recognized at the outset of the opinion by the statement that the court reverses because "the employer is a mere agent of Metropolitan for the *collection* of premiums . . . ." (*Ante,* p. 652; italics added.) So far all we have seen the employer do is pay out losses—either on its own account, as the trial court found, or on behalf of Metropolitan, as the majority asserts. Not one penny of premiums has so far been collected for pretrigger-point "coverage."

The majority gets over this final hurdle by holding that the premium is collected by the employers when they receive the labor of the insured employees. "The labor of the employees is the true source of the benefits . . . ." (*Ante,* p. 661.) The only trouble with that theory is that the tax claimed by the board has nothing to do with the value of the labor rendered by the insureds. To the contrary, the board asserts that the *losses paid* are the meas-

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[7] What about the premium savings in the 32 policy years when losses did not reach the trigger-points? Presumably the employers owe these funds to Metropolitan and, to be consistent, the board should claim that they are gross receipts. One can only speculate why it lacked the requisite chutzpah.

ure of the tax liability. Obviously when one deals with a medical benefit plan, these should be in inverse proportion to the value of the labor rendered.

It is therefore submitted that the board's effort to transform an excess policy into one that provides full coverage will not stand up. It remains to dispose of a couple of points made by the majority to assert by implication that the "symbiotic" relationship between Metropolitan and the employers can somehow make the legal realities disappear.

First, there is the point that if the 13 employers who did avail themselves of Metropolitan's claims service failed to provide sufficient funds for pretrigger-point losses, Metropolitan was nevertheless obligated to advance money to pay for the losses, subject to reimbursement by the employers—a clean debtor-creditor relationship which by no means turns Metropolitan from a creditor into an insurer. The fact that an employer may become insolvent and leave Metropolitan holding the bag is a normal risk of doing business which was, presumably, taken into account in calculating the "loading" portion of the premium for the excess coverage, on which Metropolitan concedes that it was properly taxed. In any event, the argument has no application to the two employers who handled their own claims and whose payments comprised about 73 percent of the $33 million total.

Second, the majority points to the fact that Metropolitan "determined the amount of all benefits to be paid in satisfaction of employee claims, both above and below the trigger-point, with the obligation to defend and the right to settle suits contesting rejection of claims." (*Ante*, p. 657.) There is, of course, nothing unusual in that kind of arrangement. Metropolitan's obligations under it are simply part of the "administrative services" which it rendered to the employers; its rights derive from the fact that it is, after all, an excess insurer and has a vital interest in making certain that the excess risk it insured is not pre-

maturely triggered by payment of unjustified, uninsured losses. Metropolitan's primary power to determine the extent of pretrigger-point losses is obviously subject to a covenant of good faith and fair dealing. (See *Kaiser Foundation Hospitals* v. *North Star Reinsurance Corp.* (1979) 90 Cal.Ap.3d 786, 792-793 [153 Cal.Rptr. 678]; cf. *Commercial Union Assurance Companies* v. *Safeway Stores, Inc.* (1980) 26 Cal.3d 912, 921 [164 Cal.Rptr. 709, 610 P.2d 1038].)

I would affirm.

Reynoso, J., and Barry-Deal, J.,* concurred.

Respondent's petition for a rehearing was denied November 29, 1982. Richardson, J., and Newman, J., did not participate therein.

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* Assigned by the Chairperson of the Judicial Council.

APPENDIX G

UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

JASPER BALLANCE, *et al.*
Plaintiff-Appellants,

vs.

CALIFORNIA STATE BOARD OF EQUALIZATION, *et al.*,
Defendant-Appellees.

No. 86-6192

ORDER DISMISSING THE APPEAL AS MOOT

Filed Oct. 29, 1987

Before: ALARCON and NELSON, Circuit Judges, and *MUECKE, District Court Judge.

The appeal in the above captioned action is hereby DISMISSED as moot. This case is removed from the Court Calendar for Monday November 2, 1987 in Pasadena, California.

This Court's opinion in *General Motors Corp. v. California State Board of Equalization*, 815 F.2d 305 (9th Cir. 1987), which was decided after the filing of the notice of appeal in this case, renders moot the issues set forth in the claim filed against the appellees. *See In re Charlton*, 708 F.2d 1449, 1454 (9th Cir. 1983).

We dismiss this appeal as moot because our decision in *General Motors* prevents this court from granting the relief

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*The Honorable C.A. Muecke, United States District Judge for the District of Arizona, sitting by designation.

requested by appellants in their original complaint. *See Matter of Combined Metals Reduction Co.*, 557 F.2d 179, 187 (9th Cir. 1977). Specifically, the following claims are moot for purposes of this appeal:

> Appellants' claim that appellees are collaterally estopped from collecting the tax is moot because the trial court's judgment, relied on by appellants, has been reversed by this Court.
>
> Appellants' claims relating to class certification issues are moot because, under *General Motors*, appellees' efforts to collect the tax do not inflict harm on at least some of the members of the proposed class.
>
> Appellants' request for a preliminary injunction to restrain appellees from collecting the tax until *General Motors* was decided on appeal is moot because the case has been decided.
>
> Appellants' request for a permanent injuction restraining the assessment and collection of the tax is moot because this court determined in *General Motors* that the tax is not preempted by ERISA.

In accordance with the Supreme Court's guidance in *United States v. Munsingwear*, 340 U.S. 36, 39 (1950), we dismiss this appeal and vacate the district court's judgment. This action is remanded to the district court, leaving the parties "in the same position in which they would have been" had the district court never reached a decision. *In re Charlton*, 708 F.2d at 1452. We express no opinion as to the merits of appellants' new theory advanced in the Brief In Response to the Order to Show Cause, filed October 26, 1987, that *General Motors* only controls taxation as to single employer employee benefit plans. The issue is not properly before this Court.

VACATED AND REMANDED.